

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4655

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04587

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>(D.C.) Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near - Cumberland</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>154-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Mason Road, R. 7, #9</u>				d. STREET ADDRESS <u>4003-64th. St. (16)</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Rollin Adams</u>				4. DATE OF DEATH Month Day Year <u>May 28 19 56</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 7-1891</u>	
9. AGE (in years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Mln.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Street car conorman</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Little Orleans, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Edgar Adams</u>				14. MOTHER'S MAIDEN NAME <u>Denevara McCune</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>578-10-6559</u>		17. INFORMANT Address <u>(wife) Florence M. Adams, Wash. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary sclerosis</u> (a), stating the underlying cause last. DUE TO (c) <u>?</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 29-1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 31, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Lee Silcox, Cumberland, Maryland.</u>				24a. REC'D BY REGISTRAR DATE <u>6/4/56</u>		24b. REGISTRAR'S SIGNATURE <u>Monte R. Frantz</u>	

MEDICAL CERTIFICATION

Outside of City Limits

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please state the reason therefor in the space provided. The certificate should be signed by the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give the certificate to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

19/55

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	

BUREAU V. 1

JUN 4 1956

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 8

4656

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lonaconing</u>		c. LENGTH OF STAY IN lb <u>67 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lonaconing</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Main St.</u>				d. STREET ADDRESS <u>Main St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Odilo</u> Middle <u>Baumann</u> Last <u></u>				4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 15-1888</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner of Restaurant & Tavern</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Lonaconing, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Baumann</u>				14. MOTHER'S MAIDEN NAME <u>Amelia Kinble</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W.1 212-32-8099</u>		17. INFORMANT Address <u>Marie K. Baumann, Lonaconing, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis</u> DUE TO <u></u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <u>May 31-1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/2/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Lonaconing, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George Eichhorn, Lonaconing, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>6/2/56</u>		24b. REGISTRAR'S SIGNATURE <u>Jeanette M. Boal</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JUN 6 1956

BUREAU V. S.

Within corporate limits

4588 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4588 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04589

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>022 Cumberland</u>				c. LENGTH OF STAY IN 1b <u>69 Years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>00 517 Maryland Ave.</u>				d. STREET ADDRESS <u>Southern Hotel</u> <u>137 N. Mechanic St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Gladden</u> Last <u>Bolinger</u>				4. DATE OF DEATH Month <u>May</u> Day <u>11</u> Year <u>19 56</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>March 24-1870</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Photographer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>		11. BIRTHPLACE (State or foreign country) <u>Sharpsburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Bolinger</u>				14. MOTHER'S MAIDEN NAME <u>Jane Shaw</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mary Bolinger, Cumberland, Md. 531 Md. Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>?</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>May 12-1956</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 13, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>				ADDRESS <u>Hafer</u>		24a. REC'D BY REGISTRAR <u>May 12, 1956</u> 24b. REGISTRAR'S SIGNATURE <u>W. R. Frantz, M.D.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. JONES		45		M		W		JAN 15 1910		NEW YORK	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		CAUSE OF DEATH	
123 MAIN ST. BOSTON		CLOCK REPAIRER		HIGH SCHOOL		MARRIED		NONE		HEART DISEASE	
DATE OF DEATH		PLACE OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE		BLOOD PRESSURE	
MAY 10 1956		HOME		10:00 AM		98.6		72		120/80	
SIGNATURE OF EXAMINER		TITLE		DATE		PLACE		TIME		REMARKS	
[Signature]		MEDICAL EXAMINER		MAY 11 1956		BOSTON		10:00 AM		[Remarks]	

BUREAU V. 3

MAY 15 1956

RECEIVED

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4589

CERTIFICATE OF DEATH

04590

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN Ib 2 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL AVE.		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) MR. CHARLES T. CALLAN		4. DATE OF DEATH Month MAY Day 16 Year 19 56	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/8/1872
9. AGE (In years last birthday) yrs. 83		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Merchant		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) MARYLAND, Little Orleans		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS CALLAN		14. MOTHER'S MAIDEN NAME Robert Carder, Hagerstown, Maryland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Arterio sclerosis (c) Uremia			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5:14 , 19 56 , to 5:16 , 19 56 , that I last saw the deceased alive on 5:16 , 19 56 , and that death occurred at 1:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. F. Williams		ADDRESS (Street, city or town, state) Cumberland Md	
PHYSICIAN'S NAME (Type) W. F. Williams, M.D.		DATE SIGNED 5-17-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/18/56	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cath. Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafar, Cumberland, Maryland		24a. REC'D BY REGISTRAR May 19, 1956 W.R. Frantz, M.D.	
24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. It may be related to the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6222

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

107538

ALLIANCE

MARYLAND

RESIDENT

ALLIANCE

LITTLE ROCK

2 DAYS

CONSUMPTION

RECEIVED HOSPITAL, 2 BRILL 1922

1922

MAY

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T. CALVIN

CHARLES

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BUREAU V. 5

MAY 22 1922

RECEIVED

CERTIFICATE OF DEATH

DR. FAW.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE W. VA. b. COUNTY Hampshire			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) P. O. Address Little Orleans, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS Orleans Crossroads, W. Va.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARION Middle C Last CAMPBELL		4. DATE OF DEATH Month MAY Day 11 Year 1956					
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 27, 1883		9. AGE (In years last birthday) 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm owner		11. BIRTHPLACE (State or foreign country) Hyattsville, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME FRANK CAMPBELL				14. MOTHER'S MAIDEN NAME Annale MC LAUGHLIN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address MEMORIAL HOSPITAL-MEMORIAL & WARWICK AVES.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO (b) Phlebitis Common Iliac vein left. DUE TO (c) Carcinoma breast, bilateral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cholecystitis Chronic & sub acute with stones						INTERVAL BETWEEN ONSET AND DEATH 24 hrs 1 week Approx 2 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February, 1955 , to May 11, 1956 , that I last saw the deceased alive on May 11, 1956 , and that death occurred at 7:15 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5 Washington St., DATE SIGNED May 11, 56 ACTUAL SIGNATURE W. M. Faw M.D. Wylie M. Faw M.D. Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/14/56		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George Cumberland, Maryland				24a. REC'D BY REGISTRAR May 14, 1956		24b. REGISTRAR'S SIGNATURE W. R. Frank, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the attending physician and completely filled in by the funeral director, may be related to the deceased. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

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CEVA NORDMAN & JALGEMER, ATTORNEYS AT LAW

BUREAU V. S.

MAY 15 1956

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[illegible]

4643

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN lb <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Miners Hospital</u>				d. STREET ADDRESS <u>121 Wood St.</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Louis</u> Last <u>Casey</u>				4. DATE OF DEATH Month <u>May</u> Day <u>11</u> Year <u>1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 24-1873</u>		9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Mine Supt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mine</u>		11. BIRTHPLACE (State or foreign country) <u>Franklin, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Patrick Casey</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ball</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>179-03-4943</u>		17. INFORMANT <u>Mrs. Charles Clark, Frostburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock and myocardial failure</u> DUE TO (b) <u>chronic myocarditis also had bronchial asthma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>902.0</u> DUE TO (c) _____ several yrs.						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of left femur.</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Went to get out of bed and fell to the floor.</u>					
20c. TIME OF INJURY Month, Day, Year <u>3</u> Hour <u>5-6</u> p. m. <u>1956</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Frostburg Allegany Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 11-1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-14-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Michaels Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst,</u>				ADDRESS <u>Frostburg, Md.</u>		24a. REC'D BY REGISTRAR <u>5-14-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Wm. Harvey N. Roe</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED LAST, FIRST, MIDDLE SEX AGE DATE OF BIRTH PLACE OF BIRTH		OCCUPATION PLACE OF DEATH DATE OF DEATH TIME OF DEATH	
CAUSE OF DEATH (List all causes, beginning with the immediate cause, and giving the underlying cause last)		MANNER OF DEATH (Natural, Accidental, Suicidal, Homicidal, Undetermined)	
SIGNATURE OF MEDICAL EXAMINER (Print name and title)		SIGNATURE OF WITNESSES (Print names and addresses)	
CERTIFICATE OF DEATH (This certificate is valid only when filed with the proper authorities)		FILING STAMP (Date and time of filing)	

BUREAU V. 8

MAY 21 1956

RECEIVED

DR. GROVE

4591

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE WEST VIRGINIA b. COUNTY MINERAL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 27 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MR. ALGIE GRAY CLISE				4. DATE OF DEATH Month MAY Day 17 Year 1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 5, 1887	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Day House worker Textile mill</i>				10b. KIND OF BUSINESS OR INDUSTRY WEST MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME <i>James K. Clise</i>				14. MOTHER'S MAIDEN NAME <i>Larsh Winters</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-09-5483		17. INFORMANT <i>Mrs. Algie Clise - Piedmont-Wa</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic carcinoma</i> 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Carcinoma of Sigmoid colon</i> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 1 yr. 5 yrs.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <i>April</i> , 1951, to <i>May 17</i> , 1956, that I last saw the deceased alive on <i>May 17</i> , 1956, and that death occurred at <i>2:15 PM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>D. B. Grove</i>				ADDRESS (Street, city or town, state) <i>122 S. Central Cumberland Md.</i>			
PHYSICIAN'S NAME (Type) D. B. GROVE, M.D.				DATE SIGNED <i>3-17-56</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/20/56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Philoz Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Westernport Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>E. J. Hoal</i>				ADDRESS <i>Westernport, Maryland.</i>		24a. REC'D BY REGISTRAR <i>May 18, 1956</i>	
				24b. REGISTRAR'S SIGNATURE <i>W. R. Frank, M.D.</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MINERAL

WEST VIRGINIA

DEPARTMENT

1917

RECEIVED

ST. LOUIS

CHICAGO

101 SECOND ST.

CENTRAL HOSPITAL, CENTRAL AVE.

CLUB

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MAY 2, 1917

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BUREAU V. S.

MAY 21 1917

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04594

4657

CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Flintstone</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Flintstone</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rural Star Rt</u>				d. STREET ADDRESS <u>Star Rt Flintstone</u>			
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u> First Middle Last <u>Collins</u>				4. DATE OF DEATH <u>May 11</u> 19 <u>56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Both 1862</u>	9. AGE (In years last birthday) <u>93</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own House</u>		11. BIRTHPLACE (State or foreign country) <u>Artemas Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USIT</u>	
13. FATHER'S NAME <u>Asaron Mountain</u>				14. MOTHER'S MAIDEN NAME <u>Sulizma O'Neal</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr John Davis Flintstone Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Malnutrition</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>atherosclerosis</u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Germany</u> , 19 <u>56</u> , to <u>May 11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 4</u> , 19 <u>56</u> , and that death occurred at <u>5:30 p</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. E. Ables MD</u>				DATE SIGNED <u>5/10/56</u>			
PHYSICIAN'S NAME (Type) <u>H. E. Ables</u>				ADDRESS (Street, city or town, state) <u>Hancock Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 14 1956</u>		<u>Mt Hope Cemetery</u>		<u>Artemas Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm H Knight</u>				24a. REC'D BY REGISTRAR <u>Wm H Knight</u> 24b. REGISTRAR'S SIGNATURE <u>Wm H Knight</u>			

CERTIFICATE OF DEATH

6087

Form with multiple sections for death certificate, including fields for name, date, cause of death, and location. The form is mostly blank with some faint markings.

BUREAU V. S.

MAY 15 1956

RECEIVED

4544

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 106 Walnut Street				d. STREET ADDRESS Walnut Street			
3. NAME OF DECEASED (Type or print) First CLARENCE Middle COOK Last COOK				4. DATE OF DEATH Month May Day 26 Year 1956			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-8-1880	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired-print plant				10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.		11. BIRTHPLACE (State or foreign country) Frostburg, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Cook				14. MOTHER'S MAIDEN NAME Martha Mirrick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 214-07-1916		17. INFORMANT Harry Cook, Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anteroseleasiosis, Cerebral 334x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Epilepsy, Grand Mal DUE TO (c) Chronic Pulmonary				INTERVAL BETWEEN ONSET AND DEATH 20 yrs 10 yrs 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from MAY 1955 , to MAY 26, 1956 , that I last saw the deceased alive on MAY 25, 1956 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John C. Durst M.D.				ADDRESS (Street, city or town, state) 134 E. Main Frostburg, Md.			
PHYSICIAN'S NAME (Type) John C. Durst M.D.				DATE SIGNED 5/28/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-29-1956		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.				24a. REC'D BY REGISTRAR 5-28-56		24b. REGISTRAR'S SIGNATURE Wm. Nancy N. Rose	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DR. VAN ORMER

4592

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY HARDY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MOOREFIELD 85x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 60 MEMORIAL HOSPITAL		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First ADAM Middle CRITES, SR. Last		4. DATE OF DEATH Month MAY 17, Day 19 Year 56	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 24, 1895
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR: Months 60 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY Rented a farm	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES CRITES		14. MOTHER'S MAIDEN NAME JANE OURS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 236-48-2954	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombo-cytopenic Purpura, 299X DUE TO secondary to aplastic bone marrow Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 6 weeks DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 13 May, 1956 , to 17 May, 1956 , that I last saw the deceased alive on 16 May 56 , 19 56 , and that death occurred at 4:15A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Alfred Van Ormer M.D.		ADDRESS (Street, city or town, state) 22 S. Centre St. 17 May	
PHYSICIAN'S NAME (Type) W. Alfred Van Ormer, M.D.		DATE SIGNED Cumberland, Md. 56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 19, 1956	22c. NAME OF CEMETERY OR CREMATORY Newhouse Cemetery	22d. LOCATION (City, town, or county) (State) near Rig, West Virginia.
23. FUNERAL DIRECTOR'S SIGNATURE P. E. Thush & Son		ADDRESS Moorefield, W. Va.	
24a. REC'D BY REGISTRAR May 18, 1956		24b. REGISTRAR'S SIGNATURE W. L. Frantz, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained in hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Y. H. H. H.

05/13/2004

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JATISOPH. 1815245

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WEST VIRGINIA

2810 ZHANG

637193 331845

BUREAU V. S.

MAY 21 1956

RECEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4593 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04597

Reg. Dist. No.

4

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>				c. LENGTH OF STAY IN 1b <u>30 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>00 111 Fifth St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Jesse</u> Middle <u>Gibson</u> Last <u>Crites</u>				4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>19 56</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April-11-1880</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Morefield, W.Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Jacob Crites</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Ann</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>(son) Earnest Crites, Robert St. Cumberland</u>				Address <u>Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> DUE TO <u>Chronic myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Gradual</u> <u>15 years</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 5-1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 7, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Davis Memorial Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Maryland.</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR <u>May 5, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>W.R. Trant, M.D.</u>			

STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 8

AY 0 1956

RECEIVED

4594

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04598

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>(rural) Cumberland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. at the Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Rosie</u> Middle <u>Didawick</u> Last <u>Didawick</u>				4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1956</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 6-1892</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Rosie Foreman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Rt. #3 Bowman's Addition</u> <u>(husband) John W. Didawick, Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>several years.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 19-1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 22, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Abe Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>near Ridgeley, West Virginia.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland.</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR <u>May 19, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. L. Frank, M.D.</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within 72 hours after death. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - SOCIAL WELFARE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. PLACE OF DEATH	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. SIGNATURE OF MEDICAL EXAMINER		11. SIGNATURE OF WITNESS		12. SIGNATURE OF CORONER	
13. SIGNATURE OF JURY		14. SIGNATURE OF JUDGE		15. SIGNATURE OF CLERK	

BUREAU V. 3

MAY 22 1956

RECEIVED

Without corporate seal

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4595
CERTIFICATE OF DEATH

04599

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 16 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. STREET ADDRESS CASTLE HILL	
3. NAME OF DECEASED (Type or print) GEORGE J. DONALD		4. DATE OF DEATH MAY 31 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1883 APRIL 22, 1883
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR: Months 31 Days 19 Hours 56 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mines	
11. BIRTHPLACE (State or foreign country) FROSTBURG, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN DONALD		14. MOTHER'S MAIDEN NAME CATHERINE HINEBAUGH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL CUMBERLAND, MD.	
17. INFORMANT MEMORIAL HOSPITAL CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphatic Leukemia 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Artery Disease. Old Post-infarction		INTERVAL BETWEEN ONSET AND DEATH Several Months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5.15. 1956 to 5.31. 1956 , that I last saw the deceased alive on 5.31. 1956 , and that death occurred at 8 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE M. Z. Williams M.D.		ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED 5.31.56	
PHYSICIAN'S NAME (Type) DR. W.F. WILLIAMS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 3, 1956	
22c. NAME OF CEMETERY OR CREMATORY Philos Cemetery		22d. LOCATION (City, town, or county) (State) Westport, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE George Eukhorn ADDRESS Lomaxville Md		24a. REC'D BY REGISTRAR W.L. Frantz, M.D. DATE June 4, 1956	
24b. REGISTRAR'S SIGNATURE			

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

ALLEGANY

ALLEGANY

ALLEGANY

ALLEGANY

LOUISIANA

18 DAYS

18 DAYS

CATTLE HILL

CATTLE HILL

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APRIL 23, 1956

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BUREAU V. S.

JUN 4 1956

RECEIVED

RECEIVED

Outside of City Limits

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04600

4658

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X NEAR Cumberland, rural			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEAR NEAR Cumberland, rural X		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastman Road, M-24			d. STREET ADDRESS Eastman Road, M-24		
3. NAME OF DECEASED (Type or print) First SARAH Middle VIRGINIA Last ECKARD			4. DATE OF DEATH Month May Day 11 Year 1956		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1871		9. AGE (In years last birthday) 84 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Petersburg, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME ? Wolford			14. MOTHER'S MAIDEN NAME Unobtainable		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Mrs. Orville Blubaugh Rt. # 2 Cumberland, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Maemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 3 wks. Sym.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 1, 1956 to May 11, 1956 , that I last saw the deceased alive on May 1, 1956 , and that death occurred at 3:15A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 236 Virginia Ave., DATE SIGNED 5/11/56					
ACTUAL SIGNATURE Clay E. Durrett M.D.			23b. REGISTRAR'S SIGNATURE W.R. Frank, M.D.		
PHYSICIAN'S NAME (Type) Clay E. Durrett M. D.			Cumberland, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/13/56	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George Cumberland, Md.			24a. REC'D BY REGISTRAR May 12, 1956 24b. REGISTRAR'S SIGNATURE W.R. Frank, M.D.		

MEDICAL CERTIFICATION

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MAY 15 1956

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CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DATE

ALLEGEDLY

MARYLAND

MARYLAND

ALLEGEDLY

DECEASED

6 DAYS

DECEASED

10 PENNSYLVANIA AVE.

GENERAL HOSPITAL, BALTIMORE, MD.

DATE OF DEATH

DATE OF DEATH

JAN. 20

WHITE

MALE

MARYLAND

SOPHIA T. TAYLOR

MARY T. TAYLOR

GENERAL HOSPITAL, BALTIMORE, MD.

AN Y 8

29 1956

RECEIVED

DR. DURRETT ~~Will be corporate limit~~ CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND Md		c. LENGTH OF STAY IN 1b 3 HRS. 55 MIN.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND Md.		d. STREET ADDRESS 524 FRANK'S LANE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDNA Middle E Last EVANS		4. DATE OF DEATH Month MAY Day 20 Year 19 56	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 8, 1902
9. AGE (In years, last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH C. STEWART		14. MOTHER'S MAIDEN NAME LAURA WILKES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right Massive Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Left Hemiplegia DUE TO (c) Hypertension INTERVAL BETWEEN ONSET AND DEATH 5 hrs 5 hrs 6 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 19, 1956 , to May 20, 1956 , that I last saw the deceased alive on May 19, 1956 , and that death occurred at 12:25 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Clay E. Durrett M.D.		ADDRESS (Street, city or town, state) Cumberland - Md DATE SIGNED 5/20/56	
PHYSICIAN'S NAME (Type) Clay E. Durrett			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-23-56	22c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cem	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE 5/23/56		24b. REGISTRAR'S SIGNATURE W. P. Frountz, MD	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove, carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CONFIDENTIAL - HOSPITAL NO. 1

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MAY 25 1956

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CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 211 Welsh Hill				d. STREET ADDRESS 211 Welsh Hill			
3. NAME OF DECEASED (Type or print) First JENNIE Middle EVANS Last EVANS				4. DATE OF DEATH Month May Day 26 Year 1956			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-10-1882		9. AGE (In years lost birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN ANDERSON				14. MOTHER'S MAIDEN NAME EMILY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Russell Evans, Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Rheumatoid Arthritis 722.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Heart Failure DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 30 yrs. 1 yr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1956 , to May 26, 1956 , that I last saw the deceased alive on May 26, 1956 , and that death occurred at 2 A. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 134 E. Main DATE SIGNED 5/28/56 ACTUAL SIGNATURE John C. Durst M.D. Frostburg, Md. PHYSICIAN'S NAME (Type) John C. Durst							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-28-1956		22c. NAME OF CEMETERY OR CREMATORY F'b'g. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.				24a. REC'D BY REGISTRAR DATE 5-28-56		24b. REGISTRAR'S SIGNATURE Wm. Harvey N. Roe	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

Reg. Day 111

PLACE OF DEATH		RESIDENCE	
BALTIMORE		BALTIMORE	
DATE OF DEATH		DATE OF BIRTH	
JAN 31 1956		JAN 31 1956	
TIME OF DEATH		TIME OF BIRTH	
12:00 PM		12:00 PM	
CAUSE OF DEATH		CAUSE OF DEATH	
HEART DISEASE		HEART DISEASE	
MANNER OF DEATH		MANNER OF DEATH	
NATURAL		NATURAL	
RACE		RACE	
WHITE		WHITE	
SEX		SEX	
MALE		MALE	
AGE		AGE	
65		65	
EDUCATION		EDUCATION	
HIGH SCHOOL		HIGH SCHOOL	
OCCUPATION		OCCUPATION	
LABORER		LABORER	
MARITAL STATUS		MARITAL STATUS	
MARRIED		MARRIED	
RELIGION		RELIGION	
CATHOLIC		CATHOLIC	
SIGNED BY		SIGNED BY	
J. J. JONES		J. J. JONES	
DATE		DATE	
JAN 31 1956		JAN 31 1956	

BUREAU V. 1

JAN 31 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04604

DR. WHITWORTH

4598

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 1 HR.20 MIN.			
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BABy Middle BOY Last FILES				4. DATE OF DEATH Month MAY Day 25 Year 19 56			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 25, 1956	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours Min. 1 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.	
13. FATHER'S NAME WALTER F. FILES				14. MOTHER'S MAIDEN NAME NORMA G. ROBINETTE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Prematurity DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 4:40A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Fuller B. Whitworth M.D.							
PHYSICIAN'S NAME (Type) Fuller B. Whitworth, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF May 26, 1956		22c. NAME OF CEMETERY OR CREMATORY Memorial Hospital		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Memorial Hospital, Cumberland, Maryland/				24a. REC'D BY REGISTRAR May 25, 1956			
				24b. REGISTRAR'S SIGNATURE W. K. Frank, M.D.			

MEDICAL CERTIFICATION

2160264XV0

HYDROLYTIC STABILITY 89

YIN242

TABLE 1

Y. J. J.

1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

WINDS: 11

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1. 25. 1974, 30. 1974, 1. 1975

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STEWART, G. ROBERTS

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

BUREAU V. S.

MAY 28 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04605

Within corporate limits

4599

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>73 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>210 Thomas Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Frances</u> Last <u>Fraley</u>		4. DATE OF DEATH Month <u>5</u> Day <u>7</u> Year <u>1956</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 6, 1875</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>1</u> Hours <u>15</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>County Galway, Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Michael Hayes</u>		14. MOTHER'S MAIDEN NAME <u>Mary ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Pearl Andrews, Cumberland, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>atherosclerotic heart disease</u> DUE TO (c) <u>atherosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>1 year</u> <u>2 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-3-</u> 19 <u>53</u> , to <u>5-7-</u> 19 <u>56</u> , that I last saw the deceased alive on <u>5-4-</u> 19 <u>56</u> , and that death occurred at <u>11P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L. M. [Signature]</u> M.D.		ADDRESS (Street, city or town, state) <u>57 W. [Address] Cumberland, Md.</u> DATE SIGNED <u>5-9-56</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>May 11, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Terra Alta Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Terra Alta, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>May 11, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. R. Drantz MD</u>	

MAYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 10

BUREAU N. 1

MAY 14 1956

RECEIVED

4600

CERTIFICATE OF DEATH

Reg. Dist. No.

4

DR. MIRKIN

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE W. VA. b. COUNTY MINERAL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 132 W. PIEDMONT ST.	
3. NAME OF DECEASED (Type or print) First HALLIE Middle FERN Last FRIEND		4. DATE OF DEATH Month MAY Day 11 Year 19 56	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH M JAN. 30, 1917
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator - Perfection Garment Co.		10b. KIND OF BUSINESS OR INDUSTRY W.VA.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS KISNER		14. MOTHER'S MAIDEN NAME DELSIE TICHNELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 234-44-7007	
17. INFORMANT MEMORIAL HOSPITAL-MEMORIAL & WARWICK AVES.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Primary Carcinoma of liver 155X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAY 9 , 19 56 , to MAY 11 , 19 56 , that I last saw the deceased alive on MAY 11 , 19 56 , and that death occurred at 4:30 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE A. J. MIRKIN		ADDRESS (Street, city or town, state) 115 So. Centre St. Cumberland Md.	
DATE SIGNED 5/14/56		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 14, 1956	
22c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery		22d. LOCATION (City, town, or county) (State) near Terra Alta, West Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE Markwood Funeral Home, Keyser, West Virginia.		ADDRESS	
24a. REC'D BY REGISTRAR May 14, 1956		24b. REGISTRAR'S SIGNATURE W. L. Frank, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1121415

YANG ET AL.

11

TABLE 1. *Continued*

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

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STEWART JAMES

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BUREAU V. S.

MAY 15 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04607

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg | | c. LENGTH OF STAY IN 1b 8 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital | | d. STREET ADDRESS 66 Bowery St. | |
| 3. NAME OF DECEASED (Type or print) OLIN First GUNNETT Middle Lost | | 4. DATE OF DEATH May 22, 1956 Month May Day 22 Year 19 56 | |
| 5. SEX Male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-17-1876 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Kelly-Spgfd. Tire | 11. BIRTHPLACE (State or foreign country) Maryland |
| 13. FATHER'S NAME Madison Gunnett | | 14. MOTHER'S MAIDEN NAME Ann Bowen | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 212-12-89064 | 17. INFORMANT Mrs. Olin Gunnett, Frostburg, Md. Address |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis
332x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerosis
DUE TO
(c) ? | | INTERVAL BETWEEN ONSET AND DEATH 13 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 0. 11 p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from May 11, 1952 , to May 22, 1956 , that I last saw the deceased alive on May 22, 1956 , and that death occurred at 3:05 PM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Frostburg Md. DATE SIGNED May 23 1956 | | | |
| ACTUAL SIGNATURE WOM Lane M.D. | | PHYSICIAN'S NAME (Type) WOM Lane MD | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 5-25-56 | 22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park | 22d. LOCATION (City, town, or county) (State) Frostburg, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, ADDRESS Frostburg, Md. | | 24a. REC'D BY REGISTRAR 525-56 24b. REGISTRAR'S SIGNATURE Wm. Nancy H. Roe | |

CERTIFICATE OF DEATH

| | | | | | |
|--|--|---|--|---|--|
| 1. NAME OF DECEASED
JAMES EARL RAY | | 2. SEX
Male | | 3. AGE
35 | |
| 4. DATE OF DEATH
MAY 14 1968 | | 5. TIME OF DEATH
10:00 AM | | 6. PLACE OF DEATH
FEDERAL BUREAU OF INVESTIGATION | |
| 7. CAUSE OF DEATH
HEART DISEASE | | 8. MANNER OF DEATH
NATURAL | | 9. PLACE OF BIRTH
MOBILE, ALABAMA | |
| 10. OCCUPATION
ATTORNEY | | 11. EDUCATION
HIGH SCHOOL | | 12. RELIGION
METHODIST | |
| 13. MARITAL STATUS
MARRIED | | 14. DATE OF MARRIAGE
JAN 15 1965 | | 15. NAME OF SPOUSE
JANE E. RAY | |
| 16. NAME OF PHYSICIAN
DR. J. H. HARRIS | | 17. NAME OF HOSPITAL
ST. JOSEPH'S HOSPITAL | | 18. NAME OF FUNERAL HOME
JAMES EARL RAY FUNERAL HOME | |
| 19. SIGNATURE OF PHYSICIAN
J. H. HARRIS | | 20. SIGNATURE OF DECEASED
JAMES EARL RAY | | 21. SIGNATURE OF WITNESS
JANE E. RAY | |
| 22. SIGNATURE OF REGISTRAR
J. H. HARRIS | | 23. SIGNATURE OF CLERK
J. H. HARRIS | | 24. SIGNATURE OF JURY
J. H. HARRIS | |

BUREAU V. 1

MAY 31 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04608

DR. VAN ORMER

4601

CERTIFICATE OF DEATH

Reg. Dist. No.

4

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE WEST VIRGINIA b. COUNTY GRANT | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
02 CUMBERLAND | | | | c. LENGTH OF STAY IN 1b
18 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
60 MEMORIAL HOSPITAL | | | | d. STREET ADDRESS
PETERSBURG | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First JANE Middle HARTMAN Last | | | | 4. DATE OF DEATH
Month MAY Day 11 Year 1956 | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
MARCH 4, 1871 | |
| 9. AGE (In years last birthday)
85 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
WEST VIRGINIA | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
MATTHEW COLLINS | | | | 14. MOTHER'S MAIDEN NAME
RACHEAL MICK | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
MEMORIAL HOSPITAL - CUMBERLAND, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma Gall-bladder, primary
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO
(c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Pneumonia, at. lower lobe | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town)
Petersburg | | | | 20g. (County)
West Virginia | | 20h. (State)
West Virginia | |
| 21. I certify that I attended the deceased from 25 Apr. 56 , 19 56 , to 11 May , 19 56 that I last saw the deceased alive on 10 May , 19 56 , and that death occurred at 12:30 A.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE W. A. Van Ormer | | | | ADDRESS (Street, city or town, state) Cumberland, Md. | | | |
| DATE SIGNED 11 May 56 | | | | | | | |
| PHYSICIAN'S NAME (Type) W. A. VAN ORMER, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
May 13, 1956 | | 22c. NAME OF CEMETERY OR CREMATORY
Maple Hill Cemetery | | 22d. LOCATION (City, town, or county) (State)
Petersburg, West Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Schaeffer Funeral Home, Petersburg, W. Va. | | | | ADDRESS | | 24a. REC'D BY REGISTRAR
May 12, 1956 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
W. A. Frank, M.D. | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

YAGZJJA

CHILDREN

RECEIVED

4659

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|---|----------------------------------|--|--|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rural, Pinto, Md.</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rural, Pinto, Md.</u> | | | |
| c. LENGTH OF STAY IN 1b
<u>39yrs.</u> | | | | d. STREET ADDRESS
<u>McMullen Highway</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>McMullen Highway</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Mary</u> Middle <u>Elizabeth</u> Last <u>Helmick</u> | | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>24</u> Year <u>19 56</u> | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>October 5, 1880</u> | | 9. AGE (In years last birthday)
<u>75</u> yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Denton, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Charles S. Smith</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Adeline *****</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Carlton Helmick McMullen Highway, Pinto, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hypertensive Disease</u>
<u>443X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Accelerated Cardio Vascular Dis.</u>
DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Aneurysm of thoracic aorta</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>3. 6. 19 43</u> to <u>5. 24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5. 21</u> , 19 <u>56</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>Cumberland Md.</u> DATE SIGNED <u>525-36</u> | | | | | | | |
| ACTUAL SIGNATURE <u>W. F. Williams</u> M.D. | | PHYSICIAN'S NAME (Type) <u>W. F. Williams, M.D.</u> | | | | | |
| 22a. BURIAL, CREMATION, OR REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>May 27, 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Rose Hill Cemetary</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Cumberland, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Charles L. George</u> | | | | ADDRESS
<u>Cumberland, Md.</u> | | 24a. REC'D BY REGISTRAR
<u>May 26, 1956 W.L. Frank, M.D.</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the local director of health, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | |
|------------------|--|--------|--|---------|--|------------------|--|-------------------|--|------------------|--|---------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY OF BIRTH | | COUNTRY OF BIRTH | |
| JAMES H. HARRIS | | Male | | 45 | | 1910 | | Baltimore | | Maryland | | United States | |
| MARRIAGE | | SINGLE | | MARRIED | | DATE OF MARRIAGE | | PLACE OF MARRIAGE | | CITY OF MARRIAGE | | COUNTRY OF MARRIAGE | |
| None | | None | | None | | None | | None | | None | | None | |
| OCCUPATION | | None | | None | | None | | None | | None | | None | |
| None | | None | | None | | None | | None | | None | | None | |
| CAUSE OF DEATH | | None | | None | | None | | None | | None | | None | |
| None | | None | | None | | None | | None | | None | | None | |
| MANNER OF DEATH | | None | | None | | None | | None | | None | | None | |
| None | | None | | None | | None | | None | | None | | None | |
| DATE OF DEATH | | None | | None | | None | | None | | None | | None | |
| None | | None | | None | | None | | None | | None | | None | |
| PLACE OF DEATH | | None | | None | | None | | None | | None | | None | |
| None | | None | | None | | None | | None | | None | | None | |
| CITY OF DEATH | | None | | None | | None | | None | | None | | None | |
| None | | None | | None | | None | | None | | None | | None | |
| COUNTRY OF DEATH | | None | | None | | None | | None | | None | | None | |
| None | | None | | None | | None | | None | | None | | None | |
| DATE OF DEATH | | None | | None | | None | | None | | None | | None | |
| None | | None | | None | | None | | None | | None | | None | |
| PLACE OF DEATH | | None | | None | | None | | None | | None | | None | |
| None | | None | | None | | None | | None | | None | | None | |
| CITY OF DEATH | | None | | None | | None | | None | | None | | None | |
| None | | None | | None | | None | | None | | None | | None | |
| COUNTRY OF DEATH | | None | | None | | None | | None | | None | | None | |
| None | | None | | None | | None | | None | | None | | None | |

BUREAU V. S.

MAY 29 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04610

DR. TOPPER

4602

CERTIFICATE OF DEATH

Reg. Dist. No.

4

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. LENGTH OF STAY IN 1b
20 MIN. | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | d. STREET ADDRESS
719 SYLVAN AVENUE | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MEMORIAL HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First JOHN Middle B. Last HENRY | | 4. DATE OF DEATH
Month MAY Day 6 Year 1956 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Mar 4, 1895 |
| 9. AGE (In years last birthday)
61 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during usual working life, even if retired)
TRUCK DRIVER - CITY OF CUMBERLAND | | 10b. KIND OF BUSINESS OR INDUSTRY
WEST VIRGINIA | |
| 11. BIRTHPLACE (State or foreign country)
U.S.A. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
DAVID A. HENRY | | 14. MOTHER'S MAIDEN NAME
LULA F. HESSER | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
MEMORIAL HOSPITAL - CUMBERLAND, MD. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Apr 15 , 19 56 , to May 6 , 19 56 , that I last saw the deceased alive on May 6 , 19 56 , and that death occurred at 5:10 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE John H. Topper M.D. | | ADDRESS (Street, city or town, state) DATE SIGNED 5/6/56 | |
| PHYSICIAN'S NAME (Type) John A. Topper | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
5/9/56 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Mt. Olive Meth. Cem | | 22d. LOCATION (City, town, or county) (State)
Allegany Co. Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John J. Hafer, Cumberland, Maryland | | 24a. REC'D BY REGISTRAR
May 9, 1956 | |
| | | 24b. REGISTRAR'S SIGNATURE
W. L. Hantz, M.D. | |

CERTIFICATE OF DEATH

DR. TOTTEN

ALLIANCE

MARYLAND

MARYLAND

ALLIANCE

CORNERLAND

CO. MD.

CO. MD.

119 SYLVAN AVENUE

MC GRILL HOSPITAL

JOHN

JOHN

JOHN

WHITE

WHITE

WEST VIRGINIA

TRUCK DRIVER - CITY OF CORNERLAND

LULA F. BESSER

DAVID A. HENRY

MC GRILL HOSPITAL - CORNERLAND, MD.

BUREAU V. S.

MAY 10 1956

RECEIVED

4603 CERTIFICATE OF DEATH

04611

Reg. Dist. No.

| | | | |
|--|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | c. LENGTH OF STAY IN 1b 65 Years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL | | d. STREET ADDRESS 641 LINCOLN STREET | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First NELLIE Middle I Last HENRY | | 4. DATE OF DEATH Month 5- Day 2 Year 19 56 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JUNE 19, 1989 |
| 9. AGE (In years last birthday) 66 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife | | 10b. KIND OF BUSINESS OR INDUSTRY Own House | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME WILLIAM BRANT | | 14. MOTHER'S MAIDEN NAME SARAH SHIELDS | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT William Henry, Cumberland, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Nephritis - uremia
DUE TO Hypertension
(b) Intestinal obstruction
DUE TO Very bad prolapse bladder
(c) Very bad prolapse bladder
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Late 30's treated for carcinoma of cervix | | | |
| INTERVAL BETWEEN ONSET AND DEATH One week | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 2-28, 1951 to 5-2-1956 that I last saw the deceased alive on 5-1-1956 and that death occurred at 7:35 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Wm. A. Williams | | ADDRESS (Street, city or town, state) Cumberland | |
| PHYSICIAN'S NAME (Type) Wm. A. Williams | | DATE SIGNED 5-3-56 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF May 4 1956 | |
| 22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | 22d. LOCATION (City, town, or county) (State) Cumberland, Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. A. Williams | | ADDRESS Cumberland, Md. | |
| 24a. REC'D BY REGISTRAR May 4, 1956 | | 24b. REGISTRAR'S SIGNATURE W.R. Frank, M.D. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|--|--|--|---|--|---------------------------------------|--|--|--|
| NAME OF DECEASED
WILLIAM BRAY | | AGE
62 | | SEX
MALE | | RACE
WHITE | | DATE OF DEATH
JUNE 19, 1956 | |
| PLACE OF DEATH
HOME | | CITY
BALTIMORE | | COUNTY
BALTIMORE | | STATE
MARYLAND | | ZIP CODE
21201 | |
| OCCUPATION
LABORER | | EDUCATION
8 | | MARRIAGE
M | | RELIGION
METHODIST | | CAUSE OF DEATH
HEART DISEASE | |
| IMMEDIATE CAUSE OF DEATH
CORONARY THROMBOSIS | | MORBID CAUSE OF DEATH
CORONARY Atherosclerosis | | MANNER OF DEATH
NATURAL | | CERTIFICATE NO.
12345 | | REGISTRATION NO.
67890 | |
| DATE OF BIRTH
JUNE 19, 1894 | | PLACE OF BIRTH
BALTIMORE | | MOTHER'S NAME
JANE BRAY | | FATHER'S NAME
JOHN BRAY | | DECEASED'S SIGNATURE
WILLIAM BRAY | |
| DECEASED'S ADDRESS
1234 E. BALTIMORE AVE. | | DECEASED'S PHONE NO.
123-4567 | | DECEASED'S SOCIAL SECURITY NO.
123-45-6789 | | DECEASED'S MARITAL STATUS
MARRIED | | DECEASED'S RELIGIOUS BELIEFS
METHODIST | |
| DECEASED'S OCCUPATION
LABORER | | DECEASED'S EDUCATION
8 | | DECEASED'S MARRIAGE
M | | DECEASED'S RELIGION
METHODIST | | DECEASED'S CAUSE OF DEATH
HEART DISEASE | |
| DECEASED'S IMMEDIATE CAUSE OF DEATH
CORONARY THROMBOSIS | | DECEASED'S MORBID CAUSE OF DEATH
CORONARY Atherosclerosis | | DECEASED'S MANNER OF DEATH
NATURAL | | DECEASED'S CERTIFICATE NO.
12345 | | DECEASED'S REGISTRATION NO.
67890 | |
| DECEASED'S DATE OF BIRTH
JUNE 19, 1894 | | DECEASED'S PLACE OF BIRTH
BALTIMORE | | DECEASED'S MOTHER'S NAME
JANE BRAY | | DECEASED'S FATHER'S NAME
JOHN BRAY | | DECEASED'S SIGNATURE
WILLIAM BRAY | |
| DECEASED'S ADDRESS
1234 E. BALTIMORE AVE. | | DECEASED'S PHONE NO.
123-4567 | | DECEASED'S SOCIAL SECURITY NO.
123-45-6789 | | DECEASED'S MARITAL STATUS
MARRIED | | DECEASED'S RELIGIOUS BELIEFS
METHODIST | |

RECEIVED
MAY 7 1956
BUREAU V. S.

4694 CERTIFICATE OF DEATH

04612

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|--|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
02 Cumberland, | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland, | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
607 Sedgewick St., | | | | d. STREET ADDRESS
607 Sedgewick St., | | | |
| 3. NAME OF DECEASED (Type or print)
First THERESA Middle FRANCES Last HESKETT | | | | 4. DATE OF DEATH
Month May Day 17, Year 19 56 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 9, 1895 | 9. AGE (In years last birthday)
61 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own home | | 11. BIRTHPLACE (State or foreign country)
Turners Falls, Mass. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | |
| 13. FATHER'S NAME
Dennis J. O'Leary | | | | 14. MOTHER'S MAIDEN NAME
Lucy Murphy | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No, | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Charles Z. Heskett Address 607 Sedgewick St., Cumb. Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cordial arrest
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertension and Coronary Heart Disease
DUE TO
(c) with coronary insufficiency | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Immediate
4 years. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from 20 August , 19 52 , to 17 May , 19 56 , that I last saw the deceased alive on 30 Apr. , 19 56 , and that death occurred at 6:30A M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 122 So. Centre St., DATE SIGNED
ACTUAL SIGNATURE W. Alfred Van Ormer M.D.
PHYSICIAN'S NAME (Type) W. A. VanOrmer M. D. Cumberland, Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
5/19/56 | | 22c. NAME OF CEMETERY OR CREMATORY
Philos Cemetery | | 22d. LOCATION (City, town, or county) (State)
Westernport, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Charles L. George Cumberland, Md. | | | | 24a. REC'D BY REGISTRAR
May 19, 1956 R. Frank, M.D. | | 24b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

| | | | | | | | | | | | | | | | | | | | | | | | |
|------------------|--|---------------|--|----------|--|-----------------|--|------------------------|--|----------------|--|----------------|--|-------------------|--|----------------------|--|--------------------|--|------------------------|--|------------------------|--|
| Name of Deceased | | Date of Birth | | Sex | | Race | | Marital Status | | Place of Birth | | Date of Death | | Cause of Death | | Place of Death | | Time of Death | | Signature of Physician | | Signature of Registrar | |
| John Doe | | 1900 | | Male | | White | | Married | | Maryland | | 1955 | | Heart Disease | | Home | | 10:00 AM | | J. Doe, M.D. | | J. Doe, M.D. | |
| Occupation | | Education | | Religion | | Political Party | | Social Security Number | | Last Residence | | Date of Burial | | Place of Burial | | Name of Burial Place | | Name of Undertaker | | Name of Funeral Home | | Name of Cemetery | |
| Teacher | | High School | | Catholic | | Democratic | | 123456789 | | 1234 Main St. | | 1955 | | St. Mary's Church | | St. Mary's Church | | John Doe & Co. | | John Doe & Co. | | St. Mary's Cemetery | |

BUREAU V. S.

MAY 22 1956

RECEIVED

4695

CERTIFICATE OF DEATH

Reg. Dist. No.

4

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE PENNSYLVANIA b. COUNTY BEDFORD | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | c. LENGTH OF STAY IN 1b
1 DAY | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MEMORIAL HOSPITAL | | | | d. STREET ADDRESS
HYNDMAN | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First BABY Middle BOY Last HOLLER | | | | 4. DATE OF DEATH
Month MAY Day 16 Year 1956 | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
MAY 16, 1956 | |
| 9. AGE (In years last birthday) yrs. | | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>None</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
CUMBERLAND, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
EARL RAYMOND HOLLER | | | | 14. MOTHER'S MAIDEN NAME
BETTY VIRGINIA COOK | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
<i>No</i> | | 16. SOCIAL SECURITY NO.
<i>None</i> | | 17. INFORMANT
Address
MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 776X DUE TO Prematurity
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
11 1/2 hrs |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) | | (State) | | | |
| 21. I certify that I attended the deceased from 5-16 , 19 56 , to 5-16 , 19 56 , that I last saw the deceased alive on 5-16 , 19 56 , and that death occurred at 3:30 P.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 441 N. Centre St. Cumberland Md. DATE SIGNED 5-17-56 | | | | | | | |
| ACTUAL SIGNATURE William P. James | | M.D. 441 N. Centre St. Cumberland Md. | | PHYSICIAN'S NAME (Type) William P. James | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
CREMATION | | 22b. DATE THEREOF
5/17/56 | | 22c. NAME OF CEMETERY OR CREMATORY
Memorial Hospital | | 22d. LOCATION (City, town, or county) (State)
Cumberland Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Memorial Hosp, Cumberland, Md. | | | | ADDRESS | | 24a. REC'D BY REGISTRAR
DATE May 17, 1956 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
W. R. Frank, M.D. | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

1955

PENNSYLVANIA

ALLDAY

1 DAY

GO STAD

MC DONALD HOSPITAL

MAY

BULLY

BOY

BAY

MAY 1, 1955

WHITE

MALE

CHICAGO, ILLINOIS

U.S.A.

ETTY VIRGINIA COOK

CARL RAYMOND HOLLER

MEMORIAL HOSPITAL, MEMORIAL & VAMPIER AVES.

BUREAU V. S.

MAY 18 1955

RECEIVED

4606

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|---|-------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | | | c. LENGTH OF STAY IN 1b 1 DAY | | | |
| d. NAME OF HOSPITAL OR INSTITUTION MEMORIAL & WARWICK AVES | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First GRAYSON Middle ODELL Last HOUSEHOLDER | | | | 4. DATE OF DEATH
Month MAY Day 12 Year 1956 | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1904
SEPT. 3, 1904 | 9. AGE (In years last birthday) 51 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Carman | | 10b. KIND OF BUSINESS OR INDUSTRY
Railroad | | 11. BIRTHPLACE (State or foreign country)
W. VA. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
JAMES G. HOUSEHOLDER | | | | 14. MOTHER'S MAIDEN NAME
SALOMA PEER | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes | | 16. SOCIAL SECURITY NO. 220-10-4964 | | 17. INFORMANT Gary O. Householder, Cumberland, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO Chronic Myocarditis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
24 hrs
1 yr | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. — 19
p. m. — | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 3/11/56 , 19___, to 5/12/56 , 19___, that I last saw the deceased alive on 5/12/56 , 19___, and that death occurred at 8:20 AM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 5/17/56 | | | | | | | |
| ACTUAL SIGNATURE R. Williams M.D. | | PHYSICIAN'S NAME (Type) Cumberland, Md. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 22b. DATE THEREOF May 15, 1956 | | 22c. NAME OF CEMETERY OR CREMATORY Baptist Cemetery | | 22d. LOCATION (City, town, or county) (State) Three Churches, W. Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md. | | | | 24a. REC'D BY REGISTRAR May 14, 1956 | | 24b. REGISTRAR'S SIGNATURE W. L. Frank, M.D. | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

2:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4647

CERTIFICATE OF DEATH

04615

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frostburg | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Midland | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Miners Hospital | | | | d. STREET ADDRESS

e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First JOHN Middle FRANCIS Last HUGHES | | | | 4. DATE OF DEATH
Month 5/18/1956 Day 19 Year 19 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
10/1/1874 | |
| 9. AGE (In years last birthday)
81 yrs. | | IF UNDER 1 YEAR
Months 81 Days 19 Hours 19 Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Miner | | 10b. KIND OF BUSINESS OR INDUSTRY
Coal Mine | |
| 11. BIRTHPLACE (State or foreign country)
Ireland | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
John Hughes | | | | 14. MOTHER'S MAIDEN NAME
Mary Ann Wilson | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
217-05-6605 | | 17. INFORMANT
Mrs. Annie McGowan Hughes Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Peritonitis
572.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diverticulitis
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH
10 days | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 5-9 , 19 56 , to 5-18 , 19 56 , that I last saw the deceased alive on 5-18 , 19 56 , and that death occurred at M , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Leslie R. Miles, Jr. | | | | ADDRESS (Street, city or town, state) Lonacoring, Md. | | | |
| PHYSICIAN'S NAME (Type) Leslie R. Miles, Jr., M.D. | | | | DATE SIGNED | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
5/21/1956 | | 22c. NAME OF CEMETERY OR CREMATORY
St. Micheal Cemetery | | 22d. LOCATION (City, town, or county) (State)
Frostburg, MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
George Eichhorn | | | | ADDRESS
Lonacoring, MD. | | 24a. REC'D BY REGISTRAR
DATE 5-21-56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
M. Nancy H. Roe | | | |

CERTIFICATE OF DEATH

| | | | | | |
|-------------------------------------|--|--|--|-------------------------------|--|
| NAME OF DECEASED
[Illegible] | | SEX
[Illegible] | | AGE
[Illegible] | |
| DATE OF DEATH
[Illegible] | | TIME OF DEATH
[Illegible] | | PLACE OF DEATH
[Illegible] | |
| CAUSE OF DEATH
[Illegible] | | MANNER OF DEATH
[Illegible] | | PLACE OF BIRTH
[Illegible] | |
| OCCUPATION
[Illegible] | | EDUCATION
[Illegible] | | RELIGION
[Illegible] | |
| MARITAL STATUS
[Illegible] | | DATE OF MARRIAGE
[Illegible] | | NAME OF SPOUSE
[Illegible] | |
| NAME OF NEXT OF KIN
[Illegible] | | ADDRESS OF NEXT OF KIN
[Illegible] | | CITY AND STATE
[Illegible] | |
| NAME OF PHYSICIAN
[Illegible] | | ADDRESS OF PHYSICIAN
[Illegible] | | CITY AND STATE
[Illegible] | |
| NAME OF FUNERAL HOME
[Illegible] | | ADDRESS OF FUNERAL HOME
[Illegible] | | CITY AND STATE
[Illegible] | |
| NAME OF BURIAL PLACE
[Illegible] | | ADDRESS OF BURIAL PLACE
[Illegible] | | CITY AND STATE
[Illegible] | |
| NAME OF CEMETERY
[Illegible] | | ADDRESS OF CEMETERY
[Illegible] | | CITY AND STATE
[Illegible] | |
| NAME OF INTERMENT
[Illegible] | | ADDRESS OF INTERMENT
[Illegible] | | CITY AND STATE
[Illegible] | |
| NAME OF CREMATOR
[Illegible] | | ADDRESS OF CREMATOR
[Illegible] | | CITY AND STATE
[Illegible] | |
| NAME OF BURIAL PLACE
[Illegible] | | ADDRESS OF BURIAL PLACE
[Illegible] | | CITY AND STATE
[Illegible] | |
| NAME OF CEMETERY
[Illegible] | | ADDRESS OF CEMETERY
[Illegible] | | CITY AND STATE
[Illegible] | |
| NAME OF INTERMENT
[Illegible] | | ADDRESS OF INTERMENT
[Illegible] | | CITY AND STATE
[Illegible] | |
| NAME OF CREMATOR
[Illegible] | | ADDRESS OF CREMATOR
[Illegible] | | CITY AND STATE
[Illegible] | |

BUREAU V. 8

MAY 28 1956

RECEIVED

George Washington, Washington, D.C.

| | | | |
|---|---------------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary | | d. STREET ADDRESS 133 Hanover Street | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Jessie Middle Russel Last Hutcheson | | 4. DATE OF DEATH
Month May Day 30 Year 19 56 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5/26/1872 |
| 9. AGE (In years last birthday) 84 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME John Whitefield | | 14. MOTHER'S MAIDEN NAME Elizabeth Jackson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Address P.O.Box 599 | | Allegany County Infirmary Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Hypostasis
422.2 DUE TO Chronic Myocarditis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis
DUE TO (c) Incisional Hernia | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Incisional Hernia | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 2/9/50 , 19 50 , to 5/30/56 , 19 56 , that I last saw the deceased alive on 5/30/56 , 19 56 , and that death occurred at 12:00PM from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE James E. McLean M.D. | | ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 5/31/56 | |
| PHYSICIAN'S NAME (Type) Dr. James E. McLean | | Cumberland, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF June 3, 1956 | 22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery | 22d. LOCATION (City, town, or county) (State) Lonaconing, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight, Cumberland, Maryland. | | ADDRESS June 1, 1956 REC'D BY REGISTRAR W. H. Kight, M.D. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Allegany

Allegany

Allegany

Allegany

2220

Allegany

123 New York Street

Allegany County, Maryland

May 30, 1956

Harriet

Texas

1956-11-15

White

Female

Allegany

Honolulu

Elizabeth Johnson

John Whitefield

Allegany County, Maryland

BUREAU V. 8

JUN 4 1956

RECEIVED

Allegany

Dr. James A. Nelson

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
: 4608
CERTIFICATE OF DEATH

04617

Reg. Dist. No. 4

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland, | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
6 Virginia Ave., | | d. STREET ADDRESS
6 Virginia Ave., | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First SARAH Middle CATHERINE Last INSKEEP | | 4. DATE OF DEATH
Month May Day 17, Year 19 56 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 17, 1872 |
| 9. AGE (In years last birthday) 84 yrs. | | IF UNDER 1 YEAR
Months 17, Days 19 Hours 56 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own home | |
| 11. BIRTHPLACE (State or foreign country)
Capon Bridge, W. Va. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | |
| 13. FATHER'S NAME
Mallon Pugh | | 14. MOTHER'S MAIDEN NAME
Rebecca J. Nixon | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) No, (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Miss Elizabeth Pugh 6 Virginia Ave., Cumb. Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 422.1
Uraemia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Myocarditis
DUE TO
(c) Arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH
3 wks.
6 yrs.
10 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. 19
p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June , 19 50 , to May 17 , 19 56 , that I last saw the deceased alive on May 15 , 19 56 , and that death occurred at 7:00A. M., from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 236 Virginia Ave., DATE SIGNED
ACTUAL SIGNATURE Clay E. Durrett M.D.
PHYSICIAN'S NAME (Type) Clay E. Durrett M.D. Cumberland, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
5/20/56 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Queens Point Cem. | | 22d. LOCATION (City, town, or county) (State)
Keyser, W. Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Charles L. George | | ADDRESS
Cumberland, Md. | |
| 24a. REC'D BY REGISTRAR
May 19, 1956 | | 24b. REGISTRAR'S SIGNATURE
W. L. Frank, M.D. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 22 1956

RECEIVED

4699 CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|--|----------------------------------|--|--|---|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission)
o. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
02 Cumberland | | | | c. LENGTH OF STAY IN 1b
1 day | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Memorial Hospital | | | | d. STREET ADDRESS
Rt. 6 | | | |
| 3. NAME OF DECEASED (Type or print)
First John Middle William Last Judy | | | | 4. DATE OF DEATH
Month May Day 21 Year 19 56 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
Feb. 14, 1900 | | 9. AGE (In years last birthday) yrs. 56 | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Mechanic | | 10b. KIND OF BUSINESS OR INDUSTRY
Auto | | 11. BIRTHPLACE (State or foreign country)
Petersburg, W. VA. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
George A. Judy | | | | 14. MOTHER'S MAIDEN NAME
Alice Hedrick | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
214 05 8758 | | 17. INFORMANT
Mrs. Catherine Judy Rt. 6 Cumberland, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Hypertensive Cardio-Vascular Disease
443X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____
DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. _____ p. m. _____ 19 _____ | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) _____ (County) _____ (State) _____ | | | |
| 21. I certify that I attended the deceased from Jan 1 , 19 54 , to May 21 , 19 56 , that I last saw the deceased alive on May 21 , 19 56 , and that death occurred at 2 P M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) _____ DATE SIGNED _____
ACTUAL SIGNATURE John A. Topper M.D. _____
PHYSICIAN'S NAME (Type) John A. Topper | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
5-24-1956 | | 22c. NAME OF CEMETERY OR CREMATORY
HillCrest Cem. | | 22d. LOCATION (City, town, or county) (State)
Cumberland Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Charles L. George | | | | ADDRESS
Cumberland, Md. | | 24a. REC'D BY REGISTRAR
May 25, 1956 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
W. L. Hantz, M.D. | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | |
|------------------|--|-----------------------|--|--------------------------|--|------------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Death | | Place of Death | |
| John | | Male | | 35 | | July 14, 1956 | | Baltimore, Md. | |
| Cause of Death | | Immediate Cause | | Underlying Cause | | Manner of Death | | Occupation | |
| Heart Disease | | Myocardial Infarction | | Coronary Atherosclerosis | | Natural | | None | |
| Date of Birth | | Place of Birth | | Married | | Signature of Physician | | Signature of Registrar | |
| July 14, 1921 | | Baltimore, Md. | | Yes | | [Signature] | | [Signature] | |

BUREAU V. S.

MAY 28 1956

RECEIVED

4648

CERTIFICATE OF DEATH

Reg. Dist. No. 6

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Westernport | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lonaconing | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Kookon Nurseing Home | | d. STREET ADDRESS
Jackson Street | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Morgan Middle Keplinger Last
4. DATE OF DEATH
Month 5 Day 28 Year 1956 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Jan. 23, 1898 |
| 9. AGE (In years last birthday)
58 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Lonaconing, MD. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John Keplinger | | 14. MOTHER'S MAIDEN NAME
Hulda Trenam | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
None | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Mrs. Ella Starkey, Lonaconing, MD. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of pancreas
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH
4 mo | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 5 p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 56 to May 28, 1956 , that I last saw the deceased alive on May 28, 1956 , and that death occurred at 5 A M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
James H. Wulverton Jr M.D. | | ADDRESS (Street, city or town, state) DATE SIGNED
Piedmont W. Va 5-29-56 | |
| PHYSICIAN'S NAME (Type)
J. H. Wulverton Jr M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
5/30/1956 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Old Coney Cemetery | | 22d. LOCATION (City, town, or county) (State)
Lonaconing, MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
George Eichhorn, Lonaconing, MD. | | 24a. REC'D BY REGISTRAR
DATE 5-31-56 | |
| | | 24b. REGISTRAR'S SIGNATURE
Miss Jane C Kelly | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

5,296

BUREAU V. 8

1956 JUN 7

03 AUG 74

100-443887-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4610
CERTIFICATE OF DEATH

04620
4

Reg. Dist. No.

| | | | |
|--|-------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> | | c. LENGTH OF STAY IN 1b <u>20 yrs</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> | | d. STREET ADDRESS <u>426 Furnace St</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>426 Furnace St</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Lee</u> Last <u>Kirby</u> | | 4. DATE OF DEATH Month <u>May</u> Day <u>18</u> Year <u>1956</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec. 1 1889</u> |
| 9. AGE (In years last birthday) <u>66</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee of City Engineering Dept</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>William F Kirby</u> | | 14. MOTHER'S MAIDEN NAME <u>Annie Paul</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes War I</u> | | 16. SOCIAL SECURITY NO. <u>214-05-9181</u> | |
| 17. INFORMANT Address <u>Mrs Anna Kirby - Cumberland</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Heart Disease</u>
DUE TO (c) <u></u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 day</u>
<u>6 weeks</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>3-29</u> , 19 <u>56</u> , to <u>5-18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-18</u> , 19 <u>56</u> , and that death occurred at <u>4:30 P.</u> M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Ralph W. Ballin</u> M.D. | | ADDRESS (Street, city or town, state) <u>62 Greene St Cumberland</u> DATE SIGNED <u>5-21-56</u> | |
| PHYSICIAN'S NAME (Type) <u>Ralph W. Ballin, M.D.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5/21/56</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>St Lukes Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Cumberland Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u> | | ADDRESS <u>Cumberland</u> | |
| 24a. REC'D BY REGISTRAR <u>May 21, 1956</u> | | 24b. REGISTRAR'S SIGNATURE <u>W.R. Frank, M.D.</u> | |

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, CHIEF

| | | | |
|--|--|--|--|
| PLACE OF BIRTH
(State, Territory, Possession, Country)
_____ | | SEX
Male _____ Female _____ | |
| DATE OF BIRTH
(Month, Day, Year)
_____ | | PLACE OF DEATH
(State, Territory, Possession, Country)
_____ | |
| DATE OF DEATH
(Month, Day, Year)
_____ | | TIME OF DEATH
(Hour, Minute)
_____ | |
| PLACE OF DEATH
(Street, City, State, Territory, Possession, Country)
_____ | | CAUSE OF DEATH
(Immediate Cause)
_____ | |
| CAUSE OF DEATH
(Underlying Cause)
_____ | | MANNER OF DEATH
(Natural, Accidental, Suicide, Homicide, Undetermined)
_____ | |
| SIGNATURE OF DECEASED
_____ | | SIGNATURE OF WITNESS
_____ | |
| SIGNATURE OF PHYSICIAN
_____ | | SIGNATURE OF CORONER
_____ | |
| SIGNATURE OF REGISTRAR
_____ | | SIGNATURE OF CLERK
_____ | |

BUREAU V. S.

MAY 22 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4660

CERTIFICATE OF DEATH

04621

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
6 Cumberland, Rural | | | | c. LENGTH OF STAY IN 1b
6 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
Bowling Green | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First KARL Middle DICKEY Last KOLSETH | | | | 4. DATE OF DEATH
Month May Day 3 Year 19 56 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Dec. 25, 1892 | |
| 9. AGE (In years last birthday) yrs. 63 | | IF UNDER 1 YEAR
Months 12 Days 12 Hours 12 Min. 12 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Jockey agent | | 10b. KIND OF BUSINESS OR INDUSTRY
Racing | |
| 11. BIRTHPLACE (State or foreign country)
Summerville, Mass. | | | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | | | |
| 13. FATHER'S NAME
Harry L. Kolseth | | | | 14. MOTHER'S MAIDEN NAME
Clara Estes | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Mrs. Helen Kolseth R. D. # 6 Cumberland, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Concussion of the lung
163X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) metastatic cancer of the lung | | | | | | INTERVAL BETWEEN ONSET AND DEATH
12 weeks | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 5-1- , 19 56 , to 5-2- , 19 56 , that I last saw the deceased alive on 5-2- , 19 56 , and that death occurred at 9:15A M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 57 Greene St., DATE SIGNED Lewis Brings M.D.
ACTUAL SIGNATURE Lewis Brings
PHYSICIAN'S NAME (Type) Lewis Brings M.D. Cumberland, Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
5/5/56 | | 22c. NAME OF CEMETERY OR CREMATORY
S. S. Peter & Psul's | | 22d. LOCATION (City, town, or county) (State)
Cumberland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
H. Wayne George
ADDRESS Cumberland, Maryland | | | | 24a. REC'D BY REGISTRAR
May 5, 1956 | | 24b. REGISTRAR'S SIGNATURE
W. L. Frantz M.D. | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | | | |
|-------------------|--|--------------|--|--------------|--|---------------|--|----------------|--|-----------------|--|------------------------|--|---------------|--|---------------|--|----------------|--|------------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | | Usual Residence | | Cause of Death | | Date of Death | | Time of Death | | Place of Death | | Signature of Physician | | Signature of Registrar | |
| John Doe | | Male | | 45 | | Jan. 1, 1910 | | Baltimore, Md. | | Baltimore, Md. | | Heart Disease | | Jan. 15, 1955 | | 10:00 AM | | Home | | J. Doe, M.D. | | J. Doe, M.D. | |
| Name of Informant | | Relationship | | Address | | City | | State | | Zip | | Signature of Informant | | Date | | Time | | Place | | Signature of Registrar | | Date | |
| Jane Doe | | Wife | | 123 Main St. | | Baltimore | | Md. | | 21201 | | Jane Doe | | Jan. 15, 1955 | | 10:00 AM | | Home | | J. Doe, M.D. | | Jan. 15, 1955 | |

BUREAU V. S.

MAY 9 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04622

4649 CERTIFICATE OF DEATH

Reg. Dist. No. 9

| | | | | | | | |
|---|-------------------------|---|-------------------------|---|------------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>MD.</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | TOWN | |
| TOWN <u>Frostburg</u> | | | | TOWN <u>Frostburg</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| <u>14 Grant Street</u> | | | | <u>14 Grant Street</u> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>Christopher Krauss</u> | | | | <u>5/28/1956</u> 19 | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday yrs. | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. |
| <u>Male</u> | <u>White</u> | <u>Married</u> | <u>Feb. 13th 1873</u> | <u>83</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Retired Miner</u> | | <u>Coal Mine</u> | | <u>Frostburg, MD.</u> | | <u>U.S.A.</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>Henry Krauss</u> | | | | <u>Martha E. Lemart</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>No</u> | | <u>215-20-6569</u> | | <u>Mrs. George Rendar, Frostburg, MD</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION (Daughter) | | INTERVAL BETWEEN ONSET AND DEATH | |
| <u>420.1</u> IMMEDIATE CAUSE (A) <u>CORONARY ARTERY HEART DISEASE</u> | | | | | | <u>24 YRS. 12</u> | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO | | | | <u>ARTERIOSCLEROSIS</u> | | <u>20 YRS</u> | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| <u>NONE</u> | | <u>NONE</u> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| <input type="checkbox"/> | | <u>NONE</u> | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | <u>M.</u> | | | | | |
| 22. I hereby certify that I attended the deceased from <u>5/2</u>, 19<u>56</u>, to <u>MAY 28</u>, 19<u>56</u>, that I last saw the deceased alive on <u>MAY 25</u>, 19<u>56</u>, and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | ADDRESS (Street, city, town, state) | | DATE SIGNED | | | |
| <u>George Rendar</u> | | <u>M.D. 48 Broadway - Frostburg, Md.</u> | | <u>5/29/56</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>5/31/1956</u> | | <u>German Luthern Cemetery.</u> | | <u>Frostburg, MD.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>5-31-56</u> | | <u>Mr. Harvey N. Roe</u> | | <u>George Eichhorn, Lonaconing, MD.</u> | | | |

44382

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

CERTIFICATE OF DEATH

First Name

Last Name

Age

Sex

Marital Status

Occupation

Address

City

State

Date

Time

Place

Cause

Manner

Signature of Physician

Signature of Registrar

1956

(Registrar)

BUREAU V. 2

JUN 4 1956

RECEIVED

George K. Johnson

NOTATION

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04623

4650

CERTIFICATE OF DEATH

Reg. Dist. No. 9

| | | | | | | | |
|---|-------------------------------|--|--|---|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>ALLEGANY</u> | | MARYLAND | | STATE <u>MARYLAND</u> COUNTY <u>ALLEGANY</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>ROSTBURG</u> | | LENGTH OF STAY (in this place) <u>6 days</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>MT. SAUAGE</u> | | | |
| TOWN <u>ROSTBURG</u> | | | | STREET ADDRESS (If rural, give location) <u>Church Hill</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MINERS HOSPITAL</u> | | | | | | | |
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>MARY AGNES Kuhlman</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>May 3 1956</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u> | 8. DATE OF BIRTH <u>7-11-1903</u> | 9. AGE last birthday <u>52</u> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| | | | | | Months | Days | Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWORK</u> | 11. BIRTHPLACE (State or foreign country) <u>MT. SAUAGE, MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>George Adam Kuhlman</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Adaline RARRICK</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT & ADDRESS <u>Mary M. Kuhlman, MT. SAUAGE MD.</u> | | | |
| (If Yes, give war or dates of service) | | | | | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardiovascular Renal Dis.</u> | | | | | | <u>years -</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Arteriosclerosis</u> | | | | | | <u>years -</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. M. Not while at work <input type="checkbox"/> While at work <input type="checkbox"/> | | 21e. INJURY OCCURRED | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>May 3, 1956</u> , to <u>May 3, 1956</u> , that I last saw the deceased alive on <u>May 3, 1956</u> , and that death occurred at <u>12:50 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Solm B. Davis</u> M.D. | | | | ADDRESS (Street, city, town, state) <u>Frostburg, Md.</u> | | DATE SIGNED <u>5/5/56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | | DATE THEREOF <u>May 7, 1956</u> | | NAME OF CEMETERY OR CREMATORY <u>ST. PATRICKS Cemetery</u> | | LOCATION (City, town, or county) (State) <u>MT. SAUAGE MD</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <u>Wm. Nancy N. Rae</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>HARVEY H. Zeigler</u> | | ADDRESS <u>PA Hyndman</u> | |
| DATE <u>5-6-56</u> | | | | | | | |

CERTIFICATE OF DEATH

REG. DEPT. 118

11-30

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF BIRTH
5. PLACE OF BIRTH
6. OCCUPATION
7. CAUSE OF DEATH
8. PLACE OF DEATH
9. TIME OF DEATH
10. SIGNATURE OF PHYSICIAN
11. SIGNATURE OF REGISTRAR

BUREAU V. 8

JUL 8 1956

RECEIVED

11-30

Within corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4611

CERTIFICATE OF DEATH

04624

Reg. Dist. No.

4

| | | | |
|---|--------------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | c. LENGTH OF STAY IN 1b 11/7/52 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) Herbert W. Langham | | 4. DATE OF DEATH May 7, 1956 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/4/1875 |
| 9. AGE (In years last birthday) 80 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Own Farming | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME George Langham | | 14. MOTHER'S MAIDEN NAME Susanah Smith | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Allegany County Infirmary Records | | Address P. O. Box 599 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 422.1 DUE TO Pulmonary Hypostasis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocarditis
(c) Cerebral Arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH 48 hrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Special arthritis | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 11/7/52 , 19____, to 5/7/56 , 19____, that I last saw the deceased alive on 5/7/56 , 19____, and that death occurred at 1:15A M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE James E. McLean M.D. | | ADDRESS (Street, city or town, state) 49 Greene Street DATE SIGNED May 7, 1956 | |
| PHYSICIAN'S NAME (Type) Dr. James E. McLean | | Cumberland, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF May 9, 1956 | 22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery | 22d. LOCATION (City, town, or county) (State) Moscow, Maryland. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth S. Boal | | ADDRESS Westernport, Maryland. | |
| 24a. REC'D BY REGISTRAR May 9, 1956 | | 24b. REGISTRAR'S SIGNATURE W.R. Frank, M.D. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Barber

—

Satisfied

dredge?

2824

400

Continued on Page 2

A E U

BUREAU V. S.

MAY 10 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4612 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04625

Reg. Dist. No. 4

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegheny</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
a. STATE <u>Pa.</u> b. COUNTY <u>Somerset</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | | | c. LENGTH OF STAY IN 1b
<u>11 Hrs</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Memorial Hospital</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>William</u> Middle <u>H.</u> Last <u>Legas</u> | | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>23</u> Year <u>19 56</u> | | | |
| 5. SEX
<u>male</u> | | 6. COLOR OR RACE
<u>white</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Feb. 9-1920</u> | |
| 9. AGE (In years last birthday)
<u>36</u> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Carpenter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Consolidated Engineering Co.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Indian Head, Pa.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | 13. FATHER'S NAME
<u>Andrew Legas</u> | | | |
| 14. MOTHER'S MAIDEN NAME
<u>Anna Kane</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>Yes</u> (If yes, give war or dates of service)
<u>W.W. 2</u> | | | |
| 16. SOCIAL SECURITY NO.
<u>205-16-0446</u> | | | | 17. INFORMANT
<u>Memorial Hospital records</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Subdural & epidural hemorrhage</u>
902.3
DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u>a fractured skull also had a fractured 3rd</u>
(c) <u>rib(left) & post occipital laceration of scalp.</u>
DUE TO
cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Pump.</u>
INTERVAL BETWEEN ONSET AND DEATH
<u>11 hrs</u> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Fell about 20 ft. through hole in floor, head struck water</u> | | | |
| 20c. TIME OF INJURY
Month, Day, Year
<u>8.30 a.m. 5-23 1956</u> | | 20d. INJURY OCCURRED
While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
<u>Pitt. Plate & Co.</u> | | 20f. (City or town) (County) (State)
<u>near North Branch Cumberland Allegheny Md.</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>H.V. Deming M.D.</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 23-1956</u> | | | | DATE SIGNED | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>May 26, 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Union Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Meyersdale, Pennsylvania.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Konhaus Funeral Home, Meyersdale, Pennsylvania</u> | | | | 24a. REC'D BY REGISTRAR
<u>May 25, 1956 W.L. Frantz, M.D.</u> | | 24b. REGISTRAR'S SIGNATURE | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAY 28 1956

DR. DURRETT

4613

CERTIFICATE OF DEATH

Reg. Dist. No.

4

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MEMORIAL HOSPITAL | | d. STREET ADDRESS
337 VIRGINIA AVENUE | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First AUGUST Middle LINDEMAN Last | | 4. DATE OF DEATH
Month MAY Day 30 Year 1956 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
OCT. 1, 1881 |
| 9. AGE (In years last birthday) 74 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED Machinist's Helper - Steel | | 10b. KIND OF BUSINESS OR INDUSTRY
MARYLAND | |
| 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JOHN LINDEMAN | | 14. MOTHER'S MAIDEN NAME
CYNTHIA LEASURE | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
MEMORIAL HOSPITAL - CUMBERLAND, MD. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 422.2 Thrombemia
DUE TO (b) Chronic Myocarditis
DUE TO (c) 3 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 1954 to July 30, 1956 that I last saw the deceased alive on May 29, 1956 , and that death occurred at 1:40 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Clay E. Durrett M.D. | | ADDRESS (Street, city or town, state)
Cumberland | |
| PHYSICIAN'S NAME (Type)
Clay E. Durrett, M.D. | | DATE SIGNED
5/31/56 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
June 2, 1956 | 22c. NAME OF CEMETERY OR CREMATORY
St. Luke's Cemetery | 22d. LOCATION (City, town, or county) (State)
Cumberland, Maryland. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
James F. Scarpelli, Cumberland, Maryland. | | 24a. REC'D BY REGISTRAR
May 31, 1956 | |
| | | 24b. REGISTRAR'S SIGNATURE
W. L. Frank, M.D. | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DR. MEDICINE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

DATE OF BIRTH

HOSPITAL

333 VINCENNA AVENUE

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

SEX

DATE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

333 VINCENNA AVENUE

BUREAU V. R.

JUN 4 1956

RECEIVED

4614 **CERTIFICATE OF DEATH**Reg. Dist. No. 4**1. PLACE OF DEATH**COUNTY Allegany

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Cumberland

LENGTH OF STAY (in this place)

2 mo.

HOSPITAL OR INSTITUTION OR STREET ADDRESS

Sylvan Retreat**2. USUAL RESIDENCE (HOME) OF DECEASED**STATE Maryland COUNTY Allegany

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Frostburg

STREET ADDRESS

14 Lee St.**3. NAME OF DECEASED**
(Type or Print)

(First)

(Middle)

(Last)

FrancisMarkey**4. DATE OF DEATH**

(Month)

(Day)

(Year)

May 2519565. SEX
male6. COLOR OR RACE
white7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH

9-8-18879. AGE last birthday
68 yrs.IF UNDER 1 YEAR
Months DaysIF UNDER 24 HRS.
Hours Min.10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired custodian10b. KIND OF BUSINESS OR INDUSTRY
K. of C. Lodge

11. BIRTHPLACE (State or foreign country)

Ireland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Francis Markey

14. MOTHER'S MAIDEN NAME

Bridget O'Neil

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)

No

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

218-03-6923A

17. INFORMANT & ADDRESS

Walter Yungerman, Frostburg, Md.**I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH**

402.2 IMMEDIATE CAUSE (A)

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

18. MEDICAL CERTIFICATIONPulmonary HypostasisCerebral HemorrhageChronic MyocarditisNaive Depressive Psycho

INTERVAL BETWEEN ONSET AND DEATH

12 hrs1 wk.?3 yrs.**II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.**

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year)

21e. INJURY OCCURRED

While ☐ Not while ☐
M. at work et work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 26, 1956, to May 25, 1956, that I last saw the deceased alive on May 24, 1956, and that death occurred at 1:15 M. from the causes and on the date stated above.

SIGNATURE

James B. McLean

M.D.

ADDRESS (Street, city, town, state)

49 Greene St. Cumberland 32556

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

DATE THEREOF

5-28-56

NAME OF CEMETERY OR CREMATORY

St. Michael's Cemetery

LOCATION (City, town, or county)

Frostburg, Md.

(State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

May 26, 1956 W. R. Frank, M.D.

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

J. R. Durst, Frostburg, Md.

Within 10 days after death

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

04607

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

CERTIFICATE OF DEATH

REG. NO. 100

1. CAUSE OF DEATH (State or Disease)

2. PLACE OF DEATH (City, Town, or Village)

3. SEX

4. AGE

5. DATE OF DEATH

6. TIME OF DEATH

7. PLACE OF BIRTH

8. OCCUPATION

9. MARITAL STATUS

10. EDUCATION

11. RELIGION

12. RACE

13. COLOR

14. BUILD

15. COMPLEXION

16. HAIR

17. EYES

18. MOUTH

19. NOSE

20. EARS

21. TEETH

22. SKIN

23. FINGERS

24. TOES

25. NAILS

26. SCARS

27. TATTOOS

28. OTHER MARKS

29. SIGNATURE

30. DATE

BUREAU V. 8

MAY 29 1956

RECEIVED

RECEIVED

DR. SIMONS.

4615 CERTIFICATE OF DEATH

Reg. Dist. No.

4

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE W. VA. b. COUNTY Berkley | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | | | c. LENGTH OF STAY IN 1b 23 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 60 MEMORIAL HOSPITAL | | | | d. STREET ADDRESS | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First CORA Middle I Last MC CUMBE | | | | 4. DATE OF DEATH Month MAY Day 11 Year 19 56 | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH DEC. 3 1877 | |
| 9. AGE (In years last birthday) 84 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 11. BIRTHPLACE (State or foreign country) MARYLAND Frederick | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME DANIEL YOUNG | | 14. MOTHER'S MAIDEN NAME ROZELLA KING | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address MEMORIAL HOSPITAL-MEMORIAL & WARWICK AVES. | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.0 Intestinal bleeding cause U.D.
DUE TO Generalized arteriosclerosis
DUE TO Arteriosclerotic Heart disease
DUE TO Arteriosclerotic Heart disease
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH 3 weeks | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 56 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 1952 to 5 11 , 1957, that I last saw the deceased alive on 5/11 , 1957, and that death occurred at 4:05 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE George M. Simons M.D. | | | | ADDRESS (Street, city or town, state) 128 Union St, Cumberland Md | | | |
| PHYSICIAN'S NAME (Type) George M. Simons, M.D. | | | | DATE SIGNED 5/12/57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF May 14, 1956 | | 22c. NAME OF CEMETERY OR CREMATORY Greenway Cemetery | | 22d. LOCATION (City, town, or county) (State) Berkley Springs, West. Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Hunter Funeral Home, Berkley Springs, West Va. | | | | 24a. REC'D BY REGISTRAR May 12, 1956 | | 24b. REGISTRAR'S SIGNATURE W. Frank M.D. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DE. SIMON, W. 1915 CERTIFICATE OF DEATH

MARYLAND STATE DEPT. OF HEALTH - BALTIMORE 10

EARLY SPRING, MD

33 DAYS

DE. SIMON, W.

NO. 11

WHITE

MALE

ROBERT KING

DANIEL YOUNG

BUREAU V. S.

MAY 15 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04629

Reg. Dist. No. 6

4651

| | | | | | | | |
|---|---|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Westernport</u> | | c. LENGTH OF STAY IN 1b
<u>5 yrs</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Westernport</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Riorden Road</u> | | | | d. STREET ADDRESS
<u>Riorden Road</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Francis</u> Middle <u>X. McGreevy</u> Last <u></u> | | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>22</u> Year <u>19 56</u> | | | |
| 5. SEX
<u>male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
<u>Nov. 19-1899</u> | | 9. AGE (In years last birthday)
<u>56</u> yrs. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Odd jobs</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Barton, Md.</u> | | | |
| 13. FATHER'S NAME
<u>Michael Mc Greevy</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Anna Footen</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u></u> | | 17. INFORMANT Address
<u>(brother) John McGreevy, Westernport, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Asphyxia</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Strangulation by a leather belt.</u>
DUE TO (c) <u></u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.
<u>974X</u> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Hung himself by a leather belt from an iron bracket.</u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>5</u> a. m. <u>5</u> p. m. <u>22</u> 19 <u>56</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Home</u> | | | |
| 20f. (City or town)
<u>Westernport, Md.</u> | | 20g. (County)
<u>Allegany</u> | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>H. V. Deming M.D.</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 22-1956</u> | | | | DATE SIGNED | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial May 24 56 St. Peter's</u> | | 22b. DATE THEREOF
<u>May 24 56</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Westernport, Md.</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>W. Harold Fudlak Piedmont</u> | | ADDRESS
<u></u> | | 24a. REC'D BY REGISTRAR
<u>5-24-56</u> | | | |
| 24b. REGISTRAR'S SIGNATURE
<u>Joe C. Kelly</u> | | DATE | | | | | |

MEDICAL CERTIFICATION

about

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 5

MAY 28 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4616 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04630

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>02 Cumberland</u> | | c. LENGTH OF STAY IN 1b
<u>30 Yrs.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> <u>02</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>99 D.O.A. at Memorial Hospital</u> | | | | d. STREET ADDRESS
<u>24 Virginia Ave.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>John</u> Middle <u></u> Last <u>McLaughlin</u> | | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>11</u> Year <u>19 56</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>white</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>March 24-1897</u> | |
| 9. AGE (In years last birthday)
<u>59</u> yrs. | | IF UNDER 1 YEAR
Months <u></u> Days <u></u> | | IF UNDER 24 HRS.
Hours <u></u> Min. <u></u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Service Dept. Celanese Corp. of Am.</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Lonaconing, Md.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>U.S.A.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME
<u>John Mc Laughlin</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Catherine Craig</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>214-07-2650</u> | | 17. INFORMANT
Address <u>Christy Road.</u>
<u>Mrs. Mary Atkinson, Cumberland, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary sclerosis</u>
DUE TO (c) <u></u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>sudden</u>
<u>?</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>H. V. Deming M.D.</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 11-1956</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>5-15-56</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Davis Memorial Cem.</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Cumberland, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>James F. Scarpelli</u> | | | | ADDRESS
<u>Cumberland, Md.</u> | | 24a. REC'D BY REGISTRAR
<u>May 14, 1956</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>W. L. Frantz, M.D.</u> | | | |

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
12. B MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|--|--|-------------------------------|--|
| NAME OF DECEASED

SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE | | DATE OF DEATH
_____ | |
| PLACE OF DEATH
_____ | | COUNTY
_____ | |
| OCCUPATION
_____ | | CAUSE OF DEATH
_____ | |
| MANNER OF DEATH
_____ | | MEDICAL HISTORY
_____ | |
| PREVIOUS ILLNESS
_____ | | MEDICAL OPINION
_____ | |
| SIGNATURE OF EXAMINER
_____ | | SIGNATURE OF WITNESS
_____ | |
| OFFICIAL SEAL
_____ | | OFFICIAL SEAL
_____ | |

BUREAU V. S.

MAY 15 1956

RECEIVED

With a corporate limit

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04631

Item 20b 5/17/56

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Allegany</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Md.</u> b. COUNTY <u>Allegany</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>02 Cumberland</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | |
| c. LENGTH OF STAY IN 1b
<u>4 1/2 hrs.</u> | | d. STREET ADDRESS
<u>124 Hanover St.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Sacred Heart Hospital</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>George</u> Middle <u>Frank</u> Last <u>McMullen</u> | | 4. DATE OF DEATH
Month <u>May</u> Day <u>6</u> Year <u>19 56</u> | |
| 5. SEX
<u>male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>April 19-1887</u> |
| 9. AGE (In years last birthday)
<u>69</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>retired Plasterer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Self</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Eckhart Mines, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>John Robert McMullen</u> | | 14. MOTHER'S MAIDEN NAME
<u>Mary Virginia Jordon</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>217-05-3990</u> | |
| 17. INFORMANT
<u>McMullen</u> | | Address
<u>Ruth Marie Pitt, Cumberland, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Subdural hemorrhage due to fractured Skull 4 1/2 hrs.</u>
<u>904.5</u> DUE TO <u>2-678 ribs & right clavical</u>
Conditions, if any, which gave rise to immediate cause (b) <u>Hemathorax due to fractured ribs, right side</u>
DUE TO <u> </u>
(c) <u> </u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Apparently fell.</u> | |
| 20c. TIME OF INJURY
Hour <u>11.15</u> a. m. <u> </u> p. m. <u> </u>
Day <u>May 5</u> 19 <u>56</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Hay St. 143 N.</u> | 20f. (City or town) (County) (State)
<u>Cumberland Allegany Md.</u> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>H.V. Deming M.D.</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 7-1956</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 22b. DATE THEREOF
<u>May 9, 1956</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Eckhart Cemetery</u> | 22d. LOCATION (City, town, or county) (State)
<u>Eckhart, Maryland.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>John J. Hafer, Cumberland, Maryland.</u> | | 24a. REC'D BY REGISTRAR
<u>May 9, 1956</u> | 24b. REGISTRAR'S SIGNATURE
<u>W.R. Frantz, M.D.</u> |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, please execute the certificate within the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAY 10 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | 04632 |
|--|--|----------------------------------|--|--|--|--------------------------------------|--|---|----------|--|
| DR. TOPPER | | | | | | | | | | Reg. Dist. No. 4 |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE XXMMXX PENNSYLVANIA <i>Bedford</i> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | | c. LENGTH OF STAY IN 1b
12 DAYS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
HYNDMAN FAIRHOPE <i>151-3</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MEMORIAL HOSPITAL | | | | | d. STREET ADDRESS | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print)
First HARRY Middle J. MERKEL Last | | | | | 4. DATE OF DEATH
Month MAY 21 Day 1956 | | | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
6-17-1861 | | 9. AGE (In years last birthday)
94 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Steel worker, Fairhope</i> | | | | | 10b. KIND OF BUSINESS OR INDUSTRY
PENNSYLVANIA | | | 11. BIRTHPLACE (State or foreign country)
USA | | |
| 13. FATHER'S NAME
GEORGE MERKEL | | | | | 14. MOTHER'S MAIDEN NAME
MARGARET BARD | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
UNK | | | | | 16. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
MEMORIAL HOSPITAL, MEMORIAL AVENUE | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 422.2 <i>Chronic Myocardosis</i>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 yrs |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | | | | |
| 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | (State) |
| 21. I certify that I attended the deceased from <i>Jan</i> 1957, to <i>May 21</i> 1956, that I last saw the deceased alive on <i>May 21</i> 1956, and that death occurred at <i>11:25 P</i> M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
<i>Hyndman Pa 5-21-56</i> | | | | | | | | | | |
| ACTUAL SIGNATURE <i>John C. Topper</i> M.D. <i>Hyndman Pa</i> | | | | | | | | | | |
| PHYSICIAN'S NAME (Type) DR. J. TOPPER | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | | 22d. LOCATION (City, town, or county) (State) | | | |
| <i>Buried</i> | | <i>May 24, 1956</i> | | <i>Trinity Lutheran Cemetery Cumberland, Md.</i> | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>Harvey J. Leigler Hyndman, Pa</i> | | | | | 24a. REC'D BY REGISTRAR
<i>DATE 5/23/1956</i> | | 24b. REGISTRAR'S SIGNATURE
<i>W.R. Frantz, M.D.</i> | | | |

CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| COUNTY OF PENNSYLVANIA
DEPARTMENT OF HEALTH - BALTIMORE, MD | | DEATH CERTIFICATE
NO. 1 | |
| NAME OF DECEASED
J. M. KELLY | | SEX
MALE | |
| DATE OF DEATH
MAY 21, 1956 | | TIME OF DEATH
12:00 PM | |
| PLACE OF DEATH
HOSPITAL | | CITY
BALTIMORE | |
| STREET
1234 MAIN ST | | STATE
MARYLAND | |
| ZIP CODE
21201 | | COUNTY
BALTIMORE | |
| DECEASED'S RESIDENCE
1234 MAIN ST | | CITY
BALTIMORE | |
| STATE
MARYLAND | | ZIP CODE
21201 | |
| DECEASED'S OCCUPATION
LABORER | | CAUSE OF DEATH
HEART DISEASE | |
| DECEASED'S MARITAL STATUS
SINGLE | | DECEASED'S AGE
45 | |
| DECEASED'S RACE
WHITE | | DECEASED'S SEX
MALE | |
| DECEASED'S RELIGION
CATHOLIC | | DECEASED'S EDUCATION
HIGH SCHOOL | |
| DECEASED'S BIRTH DATE
MAY 21, 1911 | | DECEASED'S BIRTH PLACE
BALTIMORE, MD | |
| DECEASED'S BIRTH TIME
12:00 PM | | DECEASED'S BIRTH WEIGHT
150 LBS | |
| DECEASED'S BIRTH HEIGHT
5' 10" | | DECEASED'S BIRTH COLOR
WHITE | |
| DECEASED'S BIRTH HAIR
BROWN | | DECEASED'S BIRTH EYES
BLUE | |
| DECEASED'S BIRTH TEETH
FULL | | DECEASED'S BIRTH SKIN
FAIR | |
| DECEASED'S BIRTH BUILD
MEDIUM | | DECEASED'S BIRTH TEMPERAMENT
SANGUINE | |
| DECEASED'S BIRTH HABITS
NONE | | DECEASED'S BIRTH OCCUPATION
LABORER | |
| DECEASED'S BIRTH RESIDENCE
1234 MAIN ST | | DECEASED'S BIRTH CITY
BALTIMORE | |
| DECEASED'S BIRTH STATE
MARYLAND | | DECEASED'S BIRTH ZIP CODE
21201 | |
| DECEASED'S BIRTH COUNTY
BALTIMORE | | DECEASED'S BIRTH DISTRICT
12 | |
| DECEASED'S BIRTH WARD
1 | | DECEASED'S BIRTH BLOCK
1 | |
| DECEASED'S BIRTH LOT
1 | | DECEASED'S BIRTH UNIT
1 | |
| DECEASED'S BIRTH TRACT
1 | | DECEASED'S BIRTH SECTION
1 | |
| DECEASED'S BIRTH SUBSECTION
1 | | DECEASED'S BIRTH ALLOTMENT
1 | |
| DECEASED'S BIRTH LOT
1 | | DECEASED'S BIRTH UNIT
1 | |
| DECEASED'S BIRTH TRACT
1 | | DECEASED'S BIRTH SECTION
1 | |
| DECEASED'S BIRTH SUBSECTION
1 | | DECEASED'S BIRTH ALLOTMENT
1 | |

BUREAU V. M.

MAY 25 1956

RECEIVED

Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04633

4661

CERTIFICATE OF DEATH

Reg. Dist. No.

4

| | | | |
|---|--------------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cresaptown
c. LENGTH OF STAY IN 1b 1 mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland
d. STREET ADDRESS 118-2
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) Andrew Jackson Miller | | 4. DATE OF DEATH
Month May Day 2 Year 1956 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH November 24, 1869 |
| 9. AGE (In years last birthday) 87 | | IF UNDER 1 YEAR: Months 2 Days 19 Hours 56 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer, retired | | 10b. KIND OF BUSINESS OR INDUSTRY Own Farm | |
| 11. BIRTHPLACE (State or foreign country) Stemple Ridge, W. Va. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME James Wesley Miller | | 14. MOTHER'S MAIDEN NAME Mahala Ann Lipeomb Miller | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | |
| 17. INFORMANT Mrs. Nell Miller | | Address Oakland, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 450.0 gummed arteriosclerosis
DUE TO (b) 5 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 5 years | | INTERVAL BETWEEN ONSET AND DEATH 5 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1950 to May 2, 1956 , that I last saw the deceased alive on April 20, 1956 , and that death occurred at 5:15 A.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 5-8-56 | | | |
| ACTUAL SIGNATURE J. T. Johnson, Jr. | | M.D. Cumberland, Md. | |
| PHYSICIAN'S NAME (Type) James T. Johnson, Jr., M.D. | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF May 5, 1956 | 22c. NAME OF CEMETERY OR CREMATORY Red House | 22d. LOCATION (City, town, or county) (State) near Oakland, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden | | ADDRESS Oakland, Md. | |
| 24a. REC'D BY REGISTRAR May 4, 1956 | | 24b. REGISTRAR'S SIGNATURE W. R. Frank, M.D. | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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RECEIVED

4662

CERTIFICATE OF DEATH

Reg. Dist. No. 6

| | | | |
|---|-------------------------------|--|---|
| 1. PLACE OF DEATH
o. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-- Westernport | | c. LENGTH OF STAY IN 1b 27 Yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stoney Run Road | | d. STREET ADDRESS Stoney Run Road | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Josephine Lovina Murphy | | 4. DATE OF DEATH May 3 1956 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 31, 1893 |
| 9. AGE (In years lost birthday) 63 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | |
| 13. FATHER'S NAME Frederick Deremer | | 14. MOTHER'S MAIDEN NAME Mollie Dawson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | |
| 17. INFORMANT Eva Metz | | Address Stoney Run Road - Westernport | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of liver
156.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c) DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH 3 months |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Apr. 27 , 19 56 , to May 3 , 19 56 , that I last saw the deceased alive on May 2 , 19 56 , and that death occurred at 7:25 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Paul R. Wilson | | DATE SIGNED May 5, 1956 | |
| PHYSICIAN'S NAME (Type) Paul R. Wilson | | ADDRESS (Street, city or town, state) Piedmont, W. Va. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF May 6, 1956 | |
| 22c. NAME OF CEMETERY OR CREMATORY Philos Cem. | | 22d. LOCATION (City, town, or county) (State) Westernport Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE E. J. Boral - Westernport Md. | | 24a. REC'D BY REGISTRAR DATE 5-5-56 | |
| 24b. REGISTRAR'S SIGNATURE W. J. Kelly | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF MARYLAND DEPARTMENT OF HEALTH

11-10-36

| | | | | | | | | | | | | | | | | | |
|------------------------|--|------------------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY | | STATE | | COUNTRY | |
| JAMES H. HARRIS | | 65 | | M | | W | | 1871 | | MARYLAND | | BALTIMORE | | MD | | USA | |
| OCCUPATION | | EDUCATION | | MARRIAGE | | RELIGION | | CAUSE OF DEATH | | MANNER OF DEATH | | PLACE OF DEATH | | CITY | | STATE | |
| RETIRED | | HIGH SCHOOL | | MARRIED | | METHODIST | | HEART DISEASE | | NATURAL | | HOSPITAL | | BALTIMORE | | MD | |
| DATE OF DEATH | | TIME OF DEATH | | HOUR | | MINUTE | | DAY | | MONTH | | YEAR | | CITY | | STATE | |
| MAY 10 1936 | | 10:30 AM | | 10 | | 30 | | MAY | | 1936 | | BALTIMORE | | MD | | USA | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF REGISTRAR | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | |
| J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | |

BUREAU V. S.

MAY 8 1936

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04635

Reg. Dist. No. 8

| | | | |
|---|----------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>Allegany</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Lonaconing</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Lonaconing</u> | |
| c. LENGTH OF STAY IN 1b
<u>87 years</u> | | d. STREET ADDRESS
<u>Church St.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Church St.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First <u>Margaret</u> Middle <u>Murphy</u> Last <u>Murphy</u> | | 4. DATE OF DEATH
Month <u>May</u> Day <u>8</u> Year <u>19 56</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Jan. 1869</u> |
| 9. AGE (In years last birthday)
<u>87</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Home work</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>at her own home</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Lonaconing, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Cornelius Murphy</u> | | 14. MOTHER'S MAIDEN NAME
<u>Mary Farrell</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO.
<u>none</u> | |
| 17. INFORMANT
<u>Mrs. Frank Rush, Pittsburg, Pa.</u> | | Address <u> </u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Generalized arteriosclerosis</u>
DUE TO
(c) <u> </u>
INTERVAL BETWEEN ONSET AND DEATH
<u>sudden</u>
<u>?</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u> </u> | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u> </u> | | 20c. TIME OF INJURY
Month, Day, Year
Hour <u> </u> a. m. <u> </u> p. m. <u>19</u> | |
| 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> | |
| 20f. (City or town)
<u> </u> | | (County)
<u> </u> (State)
<u> </u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>H. V. Deming M.D.</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 10-1956</u> | | DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>5/12/1956</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>St. Marys Cemetery</u> | | 22d. LOCATION (City, town, or county)
<u>Lonaconing, MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>George Eichhorn, Lonaconing, MD.</u> | | 24a. REC'D BY REGISTRAR
<u>5/12/56</u> | |
| ADDRESS
<u> </u> | | 24b. REGISTRAR'S SIGNATURE
<u>Janette M. Boal</u> | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAY 28 1956

RECEIVED

George Washington, 1789-1800

4619 CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|--|----------------------------------|---|---|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | | | c. LENGTH OF STAY IN 1b
5 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Sacred Heart Hospital | | | | d. STREET ADDRESS
Rt. # 1 La Vale Court | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First William Middle S. Last O'Brien | | 4. DATE OF DEATH
Month May. Day 4 Year 1956 | | | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Oct. 4, 1893 | 9. AGE (In years lost birthday)
62 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Lumber Inspector | | 10b. KIND OF BUSINESS OR INDUSTRY
Lumber C. | | 11. BIRTHPLACE (State or foreign country)
Pa. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Zacharias O'Brien | | | | 14. MOTHER'S MAIDEN NAME
Sarah Stitzer | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
236-03-1663 | | 17. INFORMANT
Chart. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) hepatic coma
DUE TO 581.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) crackles of the liver (hypertrophy)
DUE TO (c) 6 months | | INTERVAL BETWEEN ONSET AND DEATH
1 day | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 4-30 , 19 56 , to 5-4 , 19 56 , that I last saw the deceased alive on 5-3-56 , 19 56 , and that death occurred at 5:05 A. M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
L. Brings | | M.D. 57 Green St. Cumberland Md | | ADDRESS (Street, city or town, state) | | DATE SIGNED
5-4-56 | |
| PHYSICIAN'S NAME (Type)
L. Brings, M.D. | | 57 Green St., Cumberland, Md. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
burial | | 22b. DATE THEREOF
May 6, 1956 | | 22c. NAME OF CEMETERY OR CREMATORY
Maplewood Cemetery | | 22d. LOCATION (City, town, or county) (State)
Elkins West Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
James F. Scarpelli | | | | ADDRESS
Cumberland, Md. | | 24a. REC'D BY REGISTRAR
May 7, 1956 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
M. D.antz, M.D. | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

4013

Allegany

Allegany

Allegany

Allegany

(Date)

Allegany

Allegany

Allegany

Allegany

Allegany

Allegany

Allegany

Allegany

Allegany

Allegany

U.S.A.

Allegany

Allegany

Allegany

Allegany

Allegany

Allegany

Allegany

Allegany

BUREAU V. 3

MAY 9 1956

RECEIVED

4620

CERTIFICATE OF DEATH

04637

Reg. Dist. No.

| | | | | | | | |
|---|-------------------------------|--|--|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE W. VA. b. COUNTY GRANT | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | | | c. LENGTH OF STAY IN 1b 3 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL
MEMORIAL & WARWICK AVES., | | | | d. STREET ADDRESS PETERSBURG | | | |
| 3. NAME OF DECEASED (Type or print) First CARRIE Middle K Last PHARES | | | | 4. DATE OF DEATH Month MAY Day 23 Year 1956 | | | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAY 8 17, 1956 | | 9. AGE (In years last birthday) yrs. 6 | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Petersburg, West Virginia | |
| 13. FATHER'S NAME GEORGE I. PHARES | | | | 14. MOTHER'S MAIDEN NAME PAULINE RUTH MILLER | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Memorial Hospital, Cumberland, Maryland. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 760.0 Intercranial Hemorrhage DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 days |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | |
| 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from May 20, 1956 , to May 23, 1956 , that I last saw the deceased alive on May 23, 1956 , and that death occurred at 1:50 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE R. A. Reiter | | | | ADDRESS (Street, city or town, state) 112 Bedford St., Cumberland Md. | | | |
| PHYSICIAN'S NAME (Type) RALPH A. REITER | | | | DATE SIGNED 5/23/56 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF May 25, 1956 | | 22c. NAME OF CEMETERY OR CREMATORY Mt. Hebron Cemetery | | 22d. LOCATION (City, town, or county) (State) Petersburg, West Virginia. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Thrush Funeral Home, Petersburg, West Virginia. | | | | 24a. REC'D BY REGISTRAR 5/28/56 | | 24b. REGISTRAR'S SIGNATURE H. R. Frantz | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

31542

BUREAU V. B.

MAY 28 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04638

Reg. Dist. No.

4621

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>02 Cumberland</u> | | c. LENGTH OF STAY IN 1b
<u>02</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>00 Roberts St. Extended</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>John</u> Middle <u>Jacob</u> Last <u>Poole</u> | | 4. DATE OF DEATH
Month <u>May</u> Day <u>30</u> Year <u>19 56</u> | |
| 5. SEX
<u>male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>June 3-1893</u> |
| 9. AGE (In years last birthday)
<u>62</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Pipefitter helper</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>B&O.R.Ry.</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Old Town, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Samuel Poole</u> | | 14. MOTHER'S MAIDEN NAME
<u>Kesish Piper</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>705-05-4527(wife)</u> | |
| 17. INFORMANT
<u>Blanche W. Poole, Cumberland, Md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial failure</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u>Chronic myocarditis also had hypertention</u>
(a), stating the underlying cause lost. (c) <u>Diabetes mellitus</u>
INTERVAL BETWEEN ONSET AND DEATH
<u>sudden</u>
<u>several yrs</u>
<u>several years.</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour <u> </u> o. m. <u> </u> p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>H. V. Dering M.D.</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>H. V. Dering M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>June 2, 1956</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>Fairview Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Inglesmith, Pennsylvania</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>H. Lee Silcox, Cumberland, Maryland.</u> | | 24a. REC'D BY REGISTRAR
<u>June 1, 1956</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>W. L. Frantz, M.D.</u> | | DEPUTY MEDICAL EXAMINER <u>May 31-1956</u> | |

Silcox

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JUN 4 1956
BUREAU V. S.

4622

CERTIFICATE OF DEATH

Reg. Dist. No.

4

| | | | | | | | |
|---|----------------------------------|---|--|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | c. LENGTH OF STAY IN IB
2 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
MEMORIAL & WARWICK AVES., | | | | d. STREET ADDRESS
709 LEIPER ST., | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First JACOB Middle S. Last POTTS | | 4. DATE OF DEATH
Month MAY Day 24 Year 19 56 | | | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
JUNE 28, 1887 | 9. AGE (In years last birthday)
68 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Ref. Machinist Helper | | 10b. KIND OF BUSINESS OR INDUSTRY
Celanese Corp | | 11. BIRTHPLACE (State or foreign country)
PENNA, Inglesmith | | 12. CITIZEN OF WHAT COUNTRY?
U S A | |
| 13. FATHER'S NAME
JONATHAN POTTS | | | | 14. MOTHER'S MAIDEN NAME
AMANDA PERCELL | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
220-10-1917 | | 17. INFORMANT
Mary C. Potts, 709 Leiper Street, Cumberland, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Accident
4443X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cerebro - Vascular Disease
DUE TO
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 days | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July, 1954 , to May, 1956 , that I lost saw the deceased alive on May 24, 1956 , and that death occurred on 2:25 P. M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
G. Overton Himmelwright | | | | ADDRESS (Street, city or town, State)
133 Virginia Ave, Cumberland, Md. | | | |
| DATE SIGNED
5/25/56 | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
5/27/56 | | 22c. NAME OF CEMETERY OR CREMATORY
Fairview Christ. Cem | | 22d. LOCATION (City, town, or county) (State)
Bedford Co. Pennsylvania | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John J. Hafer, Cumberland, Maryland | | | | 24. REC'D BY REGISTRAR
May 26, 1956 | | | |
| | | | | 24b. REGISTRAR'S SIGNATURE
M. D. | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relayed by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|-----------------|--|-----------------|--|
| DECEASED | | MARRIAGE | |
| NAME | | NAME | |
| AGE | | AGE | |
| SEX | | SEX | |
| RACE | | RACE | |
| DATE OF BIRTH | | DATE OF BIRTH | |
| PLACE OF BIRTH | | PLACE OF BIRTH | |
| OCCUPATION | | OCCUPATION | |
| EDUCATION | | EDUCATION | |
| RELIGION | | RELIGION | |
| MANNER OF DEATH | | MANNER OF DEATH | |
| CAUSE OF DEATH | | CAUSE OF DEATH | |
| PLACE OF DEATH | | PLACE OF DEATH | |
| DATE OF DEATH | | DATE OF DEATH | |
| SIGNATURE | | SIGNATURE | |
| WITNESS | | WITNESS | |
| DOCTOR | | DOCTOR | |
| CITY | | CITY | |
| STATE | | STATE | |
| COUNTY | | COUNTY | |
| ZIP CODE | | ZIP CODE | |

BUREAU

MAY

BUREAU V. RE

MAY 29 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04640

Within corporate limits

4623

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | |
|--|---|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. LENGTH OF STAY IN 1b
7/6/50 | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Allegany County Infirmary | | | d. STREET ADDRESS
Boulevard Apartments | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First Charles Middle William Last Purl | | | 4. DATE OF DEATH
Month May Day 3 Year 19 56 | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2/7/1890 | | 9. AGE (In years last birthday)
66 yrs. |
| | | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired - Insulation & Auto Salesman | | | 10b. KIND OF BUSINESS OR INDUSTRY
Illinois | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. |
| 13. FATHER'S NAME
James Byron Purl | | | 14. MOTHER'S MAIDEN NAME
Elizabeth Ellingsworth | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes, Navy 1910 | | 16. SOCIAL SECURITY NO.
305-09-3644 | 17. INFORMANT
Address P. O. Box 599 Allegany County Infirmary Records | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Hypostasis
DUE TO Chronic Nephritis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis
DUE TO (c) Cerebral Hemorrhage | | | | | INTERVAL BETWEEN ONSET AND DEATH
48 hrs.
?
? |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Cerebral Hemorrhage | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town)
49 Greene St. | | (County)
Allegany (State)
Md. |
| 21. I certify that I attended the deceased from 7/6/50 , 19 50 , to 5/3/56 , 19 56 , that I last saw the deceased alive on 5/3/56 , 19 56 , and that death occurred at 11:55 PM , from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE
James E. McLean | | ADDRESS (Street, city or town, state)
49 Greene St. | | DATE SIGNED
May 4, 1956 | |
| PHYSICIAN'S NAME (Type)
Dr. James E. McLean | | Cumberland, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
5/7/56 | 22c. NAME OF CEMETERY OR CREMATORY
Roselawn Cemetery | | 22d. LOCATION (City, town, or county) (State)
Charleston, Illinois | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Charles L. George | | ADDRESS
Cumberland, Maryland | | 24a. REC'D BY REGISTRAR
May 5, 1956 | 24b. REGISTRAR'S SIGNATURE
W.R. Frank, M.D. |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | |
|-------------------|--|----------------------|--|----------------|--|----------------|--|---------------------|--|------------------|--|-------------------------------|--|------------------------|--|------------------------|--|
| Name of Deceased | | Age | | Sex | | Race | | Date of Death | | Place of Death | | Cause of Death | | Signature of Physician | | Signature of Registrar | |
| Charles William | | 36 | | Male | | White | | May 1, 1930 | | Birmingham, Ala. | | Pneumonia | | [Signature] | | [Signature] | |
| Residence | | Occupation | | Marital Status | | Color | | Date of Birth | | Place of Birth | | Date of Admission to Hospital | | Date of Discharge | | Date of Burial | |
| Birmingham, Ala. | | [Blank] | | Single | | White | | May 1, 1930 | | Alabama | | [Blank] | | [Blank] | | [Blank] | |
| Manner of Death | | Period of Incubation | | Time of Day | | Month | | Year | | Day | | Hour | | Minute | | Second | |
| Natural | | [Blank] | | [Blank] | | May | | 1930 | | 1 | | [Blank] | | [Blank] | | [Blank] | |
| Name of Physician | | Name of Hospital | | Name of Nurse | | Name of Doctor | | Name of Pathologist | | Name of Coroner | | Name of Undertaker | | Name of Burial Place | | Name of Cemetery | |
| [Blank] | | [Blank] | | [Blank] | | [Blank] | | [Blank] | | [Blank] | | [Blank] | | [Blank] | | [Blank] | |

RECEIVED
BUREAU V. S.
MAY 3 1930

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4624

CERTIFICATE OF DEATH

04641

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lonaconing | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Sacred Heart Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| e. STREET ADDRESS
Dudley Street | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Lillian Middle Reiber Last Reiber | | | | 4. DATE OF DEATH
Month May Day 23 Year 1956 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
July 31, 1882 | |
| 9. AGE (In years last birthday)
73 yrs. | | IF UNDER 1 YEAR
Months 73 Days 73 Hours 73 Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House Work | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 11. BIRTHPLACE (State or foreign country)
Barton, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Thomas Mowbray | | 14. MOTHER'S MAIDEN NAME
Jane Ann Emerson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT
Mrs. Helen Dillon | | Address
Lonaconing, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis
332X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerosis Cerebral & Generalized
DUE TO
(c) Consecutive Heart Failure | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2h | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Consecutive Heart Failure | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour 9 p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town)
Lonaconing | | | | 20g. (County)
Allegany | | 20h. (State)
Md. | |
| 21. I certify that I attended the deceased from July 23, 1956 to May 23, 1956 , that I last saw the deceased alive on May 23, 1956 , and that death occurred at 7:45 M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
George J. Richards | | | | ADDRESS (Street, city or town, state)
Lonaconing, Md. | | | |
| DATE SIGNED
5-24-56 | | | | | | | |
| PHYSICIAN'S NAME (Type)
George J. Richards, Jr., M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
May 27, 1956 | | 22c. NAME OF CEMETERY OR CREMATORY
Laurel Hill Cemetery | | 22d. LOCATION (City, town, or county) (State)
Moscow, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
George Eichhorn | | | | ADDRESS
Lonaconing, Md. | | 24a. REC'D BY REGISTRAR
May 25, 1956 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
W. H. Frank, M.D. | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|------------------|--|-----------------|--|----------------|--|-----------------|--|-------------------|--|------------------|--|------------------|--|-----------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | MARRIAGE | | EDUCATION | | OCCUPATION | | RESIDENCE | |
| JAMES H. HARRIS | | 45 | | M | | W | | MARRIED | | HIGH SCHOOL | | LABORER | | BALTIMORE, MD. | |
| DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | PERIOD OF ILLNESS | | PREVIOUS ILLNESS | | HISTORY OF DEATH | | SIGNATURE OF DECEASED | |
| MAY 28, 1956 | | BALTIMORE, MD. | | HEART DISEASE | | NATURAL | | 2 WEEKS | | NONE | | NONE | | NONE | |
| TIME OF DEATH | | PLACE OF BURIAL | | CITY OF DEATH | | STATE OF DEATH | | COUNTRY OF DEATH | | CITY OF BIRTH | | STATE OF BIRTH | | COUNTRY OF BIRTH | |
| 10:00 AM | | BALTIMORE, MD. | | BALTIMORE, MD. | | MARYLAND | | UNITED STATES | | BALTIMORE, MD. | | MARYLAND | | UNITED STATES | |
| DATE OF BURIAL | | PLACE OF BURIAL | | CITY OF BURIAL | | STATE OF BURIAL | | COUNTRY OF BURIAL | | CITY OF BIRTH | | STATE OF BIRTH | | COUNTRY OF BIRTH | |
| MAY 29, 1956 | | BALTIMORE, MD. | | BALTIMORE, MD. | | MARYLAND | | UNITED STATES | | BALTIMORE, MD. | | MARYLAND | | UNITED STATES | |
| TIME OF BURIAL | | PLACE OF BURIAL | | CITY OF BURIAL | | STATE OF BURIAL | | COUNTRY OF BURIAL | | CITY OF BIRTH | | STATE OF BIRTH | | COUNTRY OF BIRTH | |
| 11:00 AM | | BALTIMORE, MD. | | BALTIMORE, MD. | | MARYLAND | | UNITED STATES | | BALTIMORE, MD. | | MARYLAND | | UNITED STATES | |
| DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | PERIOD OF ILLNESS | | PREVIOUS ILLNESS | | HISTORY OF DEATH | | SIGNATURE OF DECEASED | |
| MAY 28, 1956 | | BALTIMORE, MD. | | HEART DISEASE | | NATURAL | | 2 WEEKS | | NONE | | NONE | | NONE | |
| TIME OF DEATH | | PLACE OF BURIAL | | CITY OF DEATH | | STATE OF DEATH | | COUNTRY OF DEATH | | CITY OF BIRTH | | STATE OF BIRTH | | COUNTRY OF BIRTH | |
| 10:00 AM | | BALTIMORE, MD. | | BALTIMORE, MD. | | MARYLAND | | UNITED STATES | | BALTIMORE, MD. | | MARYLAND | | UNITED STATES | |
| DATE OF BURIAL | | PLACE OF BURIAL | | CITY OF BURIAL | | STATE OF BURIAL | | COUNTRY OF BURIAL | | CITY OF BIRTH | | STATE OF BIRTH | | COUNTRY OF BIRTH | |
| MAY 29, 1956 | | BALTIMORE, MD. | | BALTIMORE, MD. | | MARYLAND | | UNITED STATES | | BALTIMORE, MD. | | MARYLAND | | UNITED STATES | |
| TIME OF BURIAL | | PLACE OF BURIAL | | CITY OF BURIAL | | STATE OF BURIAL | | COUNTRY OF BURIAL | | CITY OF BIRTH | | STATE OF BIRTH | | COUNTRY OF BIRTH | |
| 11:00 AM | | BALTIMORE, MD. | | BALTIMORE, MD. | | MARYLAND | | UNITED STATES | | BALTIMORE, MD. | | MARYLAND | | UNITED STATES | |

BUREAU V. S.

MAY 28 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4664

CERTIFICATE OF DEATH

04642

Reg. Dist. No. 8

| | | | | | | | |
|---|---|---|---|---|---|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Allegany | | MARYLAND | | STATE MD. | | COUNTY Allegany | |
| CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN Lonaconing | | LENGTH OF STAY (in this place)
64 | | CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN Lonaconing | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
Jackson street | | | | STREET ADDRESS (If rural give location)
Jackson Street | | | |
| 3. NAME OF DECEASED
(Type or Print) Bearl L Richardson | | | | 4. DATE OF DEATH
(Month) (Day) (Year)
5/30/1956 19 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
Widowed | 8. DATE OF BIRTH
1/20/1892 | | 9. AGE last birthday
64 yrs. | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housework | | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Lonaconing, MD. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Charles Devault | | | | 14. MOTHER'S MAIDEN NAME
Fredrica Metz | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of service)
NO | | | 16. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT & ADDRESS
MRS. JOHN DONALDSON, Daughter. | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION
Lonaconing, MD. | | INTERVAL BETWEEN ONSET AND DEATH | |
| 592X IMMEDIATE CAUSE (A) Congestive Heart Failure. | | | | | | 1 mo. | |
| ANTECEDENT CAUSE(S) DUE TO (B) Uremia | | | | | | 2 mo. | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Chronic Glomerular Nephritis | | | | | | 2-3 years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21e. INJURY OCCURRED | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from 1954 , 19 5/30 , 19 56 ; that I last saw the deceased alive on 5/30 , 19 56 , and that death occurred at 11 A. M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE
George Richardson | | | | ADDRESS (Street, city, town, state)
Lonaconing Md | | DATE SIGNED
6/1/56 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | DATE THEREOF
6/2/1956 | | NAME OF CEMETERY OR CREMATORY
Oak Hill Cemetery | | LOCATION (City, town, or county) (State)
Lonaconing, MD. | |
| 24. REC'D BY REGISTRAR
DATE 6/2/56 | | REGISTRAR'S SIGNATURE
Joanette M Boal | | 25. FUNERAL DIRECTOR'S SIGNATURE
George Eichhorn, Lonaconing, MD. | | | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

| | | | |
|---|----------------------------|----------------------------------|---|
| Name of Deceased
John Doe | Date of Death
1/15/1982 | Place of Death
Jackson Street | Age
45 |
| Sex
Male | Race
White | Marital Status
Married | Cause of Death
Heart Disease |
| Usual Residence
123 Main St, Baltimore, MD | Date of Birth
1/1/1937 | Name of Physician
Dr. Smith | Name of Hospital
St. Mary's Hospital |
| Signed and sealed this 15th day of January, 1982.

Registrar | | | |

BUREAU V. 3

JUN 9 1982

RECEIVED

This certificate is valid only when used in connection with the Maryland State Department of Health - Baltimore, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, Film 198 6-11-56 et

4665

CERTIFICATE OF DEATH

Reg. Dist. No.

04643

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md.</u> <u>Allegany</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Nikep</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Nikep</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print)
First <u>Abraham Lincoln</u> Middle <u>Roberts</u> Last | | 4. DATE OF DEATH
Month <u>May</u> Day <u>30</u> Year <u>1956</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>1886</u>
<u>Aug. 9, 1886</u> |
| 9. AGE (In years last birthday)
<u>69</u> yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | 11. IF UNDER 24 HRS.
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Filter Plant Operator</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Paper Mill</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Barton-Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>James Roberts</u> | | 14. MOTHER'S MAIDEN NAME
<u>Hannah Johnson</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>214-05-8014</u> | |
| 17. INFORMANT
<u>John Roberts</u> | | Address
<u>Barton, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral & generalized arteriosclerosis</u>
DUE TO
(c) <u>2 yrs.</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>18 hrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>July 1953</u> , to <u>30 May 1956</u> , that I last saw the deceased alive on <u>29 May 1956</u> , and that death occurred at <u>3:20 AM</u> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
<u>George R. Richards</u> M.D. <u>51 Main, Lonaconing, Md</u> <u>5/30/56</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>6/2/56</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>Laurel Hill</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Moscow</u> <u>Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>E. J. Boral</u> | | 24a. REC'D BY REGISTRAR
DATE <u>6/2/56</u> | |
| ADDRESS
<u>Westernport, Md.</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Jannette M. Boal</u> | |

CERTIFICATE OF DEATH

MAINTAINED STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

100000

| | | | | | | | | | | | | | | | |
|-----------------------|--|----------------------|--|------------------------|--|-----------------------|--|----------------------|--|--------------------|--|--------------------|--|------------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY | | STATE | | COUNTRY | |
| JAMES EARL RAY | | MALE | | 35 | | 1928 | | MOBILE | | ALABAMA | | UNITED STATES | | UNITED STATES | |
| RACE | | COLOR | | RELIGION | | MARRIAGE | | EDUCATION | | OCCUPATION | | CAUSE OF DEATH | | MANNER OF DEATH | |
| WHITE | | WHITE | | METHODIST | | MARRIED | | HIGH SCHOOL | | BUSINESSMAN | | HEART DISEASE | | NATURAL | |
| DATE OF DEATH | | PLACE OF DEATH | | CITY | | STATE | | COUNTRY | | DATE OF BURIAL | | PLACE OF BURIAL | | CITY | |
| JUN 6 1968 | | MEMPHIS | | TENNESSEE | | UNITED STATES | | UNITED STATES | | JUN 7 1968 | | MEMPHIS | | TENNESSEE | |
| SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | | SIGNATURE OF PHYSICIAN | | SIGNATURE OF MINISTER | | SIGNATURE OF CORONER | | SIGNATURE OF JUDGE | | SIGNATURE OF CLERK | | SIGNATURE OF REGISTRAR | |
| | | | | | | | | | | | | | | | |

BUREAU V. S.

JUN 6 1968

RECEIVED

With a corporate limit

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04644

4625

Reg. Dist. No. 4

| | | | |
|---|------------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>P.O. Flintstone</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>D.O.A. at Sacred Heart Hospital</u> | | d. STREET ADDRESS
<u>Green Ridge Camp.</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Zed</u> Middle <u>Edwin</u> Last <u>Rodgers</u> | | 4. DATE OF DEATH
Month <u>May</u> Day <u>4</u> Year <u>19 56</u> | |
| 5. SEX
<u>male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>June 11-1913</u> |
| 9. AGE (In years last birthday)
<u>42</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Cottage Master, Boys Forestry Camp.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>S. Dept of Welfare</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Wards, S. Carolina</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Zed Rodgers</u> | | 14. MOTHER'S MARDEN NAME
<u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>Yes</u> <input checked="" type="checkbox"/> (If yes, give war or dates of service)
<u>W.W. 2</u> | | 16. SOCIAL SECURITY NO.
<u>249-18-4131</u> | |
| 17. INFORMANT
<u>(wife) Sarah Rodgers</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary artery occlusion</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis</u>
DUE TO (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>sudden</u>
<u>?</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>H.V. Deming M.D.</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 5-1956</u> | | DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 22b. DATE THEREOF
<u>5/8/56</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Bethel Cemetery</u> | 22d. LOCATION (City, town, or county) (State)
<u>Woodruff, S. Carolina</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Charles L. George</u> | | 24a. REC'D BY REGISTRAR
<u>May 7, 1956</u> | |
| ADDRESS
<u>Cumberland, Maryland</u> | | 24b. REGISTRAR'S SIGNATURE
<u>W.L. Frank, M.D.</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Form 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAY 9 1951

RECEIVED

4626

CERTIFICATE OF DEATH

Reg. Dist. No.

4

| | | | |
|---|-------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland | | c. LENGTH OF STAY IN 1b 12/16/53 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 91 Allegany County Infirmary | | d. STREET ADDRESS 52 Marion Street | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First William Middle P. Last Rollins | | 4. DATE OF DEATH
Month May Day 2, Year 19 56 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2/15/1869 |
| 9. AGE (In years last birthday) 87 yrs. | | IF UNDER 1 YEAR: Months 87 Days 87 Hours 87 Min. 87 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Drayman - Hauling | | 10b. KIND OF BUSINESS OR INDUSTRY Pratt, Maryland | |
| 11. BIRTHPLACE (State or foreign country) U. S. A. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Thomas J. Rollins | | 14. MOTHER'S MAIDEN NAME Sarah E. Hanna | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None | |
| 17. INFORMANT Allegany County Infirmary Records | | Address P.O. Box 599 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis
DUE TO Sudden
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) General Arteriosclerosis
DUE TO ?
(c) Chronic Nephritis
DUE TO ? | | INTERVAL BETWEEN ONSET AND DEATH Sudden | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Total Bloodless | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 12/16/53 , 19____, to 5/2/56 , 19____, that I last saw the deceased alive on 5/2/56 , 19____, and that death occurred at 10:23A M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 5/2/56 | | | |
| ACTUAL SIGNATURE James E. McLean M.D. | | DATE SIGNED 5/2/56 | |
| PHYSICIAN'S NAME (Type) Dr. James E. McLean | | Cumberland, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/4/56 | |
| 22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery | | 22d. LOCATION (City, town, or county) (State) Cumberland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE H. John J. Hafer | | ADDRESS Cumberland, Maryland | |
| 24a. REC'D BY REGISTRAR May 3, 1956 | | 24b. REGISTRAR'S SIGNATURE Walter R. Trant, M.D. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Barthelme, R. 1992.

Thomas J. Rolins

BUREAU V. S.

RECEIVED
MAY 4 1956

1956 4 MAY

DR. R. J. WMS,

4627 CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | | | c. LENGTH OF STAY IN 1b 7 HRS. 30 MINS. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL | | | | d. STREET ADDRESS 307 HELEN ST. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First MIDDLE Last ROGER H ROW | | | | 4. DATE OF DEATH Month MAY Day 13 Year 1956 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH NOV. 23, 1914 | |
| 9. AGE (In years last birthday) 41 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Agent | | | | 10b. KIND OF BUSINESS OR INDUSTRY Insurance Company | | | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME JOHN W. ROW | | | | 14. MOTHER'S MAIDEN NAME BORO IVA MANN | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT Address MEMORIAL HOSPITAL-MEMORIAL & WARWICK AVES. | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Nephritis
592x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Had Reiter's Syndrome 1 yr ago
INTERVAL BETWEEN ONSET AND DEATH 1 yr | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 4/30/56, 19, to 5/13/56, 19, that I last saw the deceased alive on 5/13/56, 19, and that death occurred at 5:30 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
ACTUAL SIGNATURE R. J. Williams M.D. CUMBERLAND, MD. 5/13/56
PHYSICIAN'S NAME (Type) R. J. Williams CUMBERLAND, MD. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF May 16, 1956 | | 22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery | | 22d. LOCATION (City, town, or county) (State) Cumberland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS William H. Kight, Cumberland, Maryland. | | | | 24a. REC'D BY REGISTRAR May 14, 1956 | | 24b. REGISTRAR'S SIGNATURE W. R. Frantz, M.D. | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1957 CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible] RACE: [illegible]

DATE OF DEATH: [illegible] TIME OF DEATH: [illegible]

PLACE OF DEATH: [illegible] CITY: [illegible] STATE: [illegible]

CAUSE OF DEATH: [illegible] MANNER OF DEATH: [illegible]

DECEASED'S RESIDENCE: [illegible] DATE OF BIRTH: [illegible]

DECEASED'S OCCUPATION: [illegible] DECEASED'S MARITAL STATUS: [illegible]

DECEASED'S EDUCATION: [illegible] DECEASED'S RELIGION: [illegible]

DECEASED'S SOCIAL SECURITY NUMBER: [illegible] DECEASED'S VOTER REGISTRATION: [illegible]

DECEASED'S LAST KNOWN ADDRESS: [illegible] DECEASED'S LAST KNOWN PHONE NUMBER: [illegible]

DECEASED'S LAST KNOWN EMPLOYER: [illegible] DECEASED'S LAST KNOWN EMPLOYMENT DATE: [illegible]

DECEASED'S LAST KNOWN ADDRESS: [illegible] DECEASED'S LAST KNOWN PHONE NUMBER: [illegible]

DECEASED'S LAST KNOWN EMPLOYER: [illegible] DECEASED'S LAST KNOWN EMPLOYMENT DATE: [illegible]

BUREAU V. 8

MAY 15 1956

RECEIVED

1
Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4628

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04647

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>02 Cumberland</u> | | | | c. LENGTH OF STAY IN 1b
<u>55 Yrs.</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>00 625 Patterson Ave.</u> | | | | d. STREET ADDRESS
<u>625 Patterson Ave.</u> | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Otto</u> Middle <u>Henry</u> Last <u>Ruehl</u> | | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>10</u> Year <u>19 56</u> | | | |
| 5. SEX
<u>male</u> | | 6. COLOR OR RACE
<u>white</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Oct. 18-1900</u> | |
| 9. AGE (In years last birthday)
<u>55</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired Brewer worker-Queen City</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Brewing Co.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Cumberland, Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME
<u>William Ruehl</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Sophia Schneider</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>214-05-5834</u> | | 17. INFORMANT
Address <u>(wife) Lucy May Ruehl, Cumberland, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hemoptysis</u>
DUE TO (b) <u>Ruptured dissecting aneurism of the aorta</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>into the lungs also had cardiac hypertrophy (marked)</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>sudden</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>H. V. Deming M.D.</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 10-1956</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>May 12, 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Sts. Peter & Paul Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Cumberland, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Charles L. George, Cumberland, Maryland.</u> | | | | 24a. REC'D BY REGISTRAR
<u>May 12, 1956</u> | | 24b. REGISTRAR'S SIGNATURE
<u>W. L. Frank, M.D.</u> | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

BUREAU V. S.

4652

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg | | c. LENGTH OF STAY IN life life | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 40 Wright St. | | d. STREET ADDRESS 40 Wright St. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First OSCAR Middle S. Last SAVAGE | | 4. DATE OF DEATH Month May Day 5 Year 1956 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4-18-1904 |
| 9. AGE (In years last birthday) 52 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service man | | 10b. KIND OF BUSINESS OR INDUSTRY Potomac Edison Co. | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME George M. Savage | | 14. MOTHER'S MAIDEN NAME Hattie V. Murphy | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 214-10-5075 | |
| 17. INFORMANT Mrs. Vivian E. Savage, Frostburg, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cardiac Distention
DUE TO Chronic Myocardial Insufficiency
DUE TO Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH
Sudden
6 mo
Several years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Oct 22, 1925 , to May 5, 1956 , that I last saw the deceased alive on Apr 30, 1956 , and that death occurred at 4:00 PM , from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) Frostburg, Md. | |
| ACTUAL SIGNATURE W. M. C. Lane M.D. | | DATE SIGNED May 7, 1956 | |
| PHYSICIAN'S NAME (Type) W. M. C. Lane | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 5-8-56 | 22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park | 22d. LOCATION (City, town, or county) (State) Frostburg, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, ADDRESS Frostburg, Md. | | 24a. REC'D BY REGISTRAR 5-9-56 24b. REGISTRAR'S SIGNATURE Mrs. Nancy N. Roe | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 15 1956

RECEIVED

4629

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

| | | | | | |
|---|--|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>W. Va.</u> b. COUNTY <u>Hampshire</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Romney</u> 85x-3 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>D.O.A. At the Memorial Hospital</u> | | | d. STREET ADDRESS | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Larry</u> Middle <u>Donald</u> Last <u>Saville</u> | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>19</u> Year <u>19 56</u> | | |
| 5. SEX
<u>male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Aug. 23-1936</u> | | 9. AGE (In years last birthday)
<u>19</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Construction</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Augusta, W. Va.</u> | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> |
| 13. FATHER'S NAME
<u>Roy L. Saville</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Dollie Snyder</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>234-56-5356</u> | | 17. INFORMANT
<u>(father) Roy L. Saville, Romney, W. Va.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Intracranial hemorrhage</u>
DUE TO
(b) <u>Crushed skull</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) <u>Auto accident in W. Va.</u>
INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 1 | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driver lost control of auto, making a turn, auto hit steel post & tree.</u> | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m.
<u>12-20-56</u> <u>5-19</u> <u>19 56</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Highway Rt. 50</u> | | 20f. (City or town)
<u>Romney</u> | (County)
<u>Hampshire</u> |
| (State)
<u>W. Va.</u> | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE
<u>H. V. Deming M.D.</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type)
<u>H. V. Deming M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 19-1956</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 22b. DATE THEREOF
<u>May 21, 1956</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Salem Methodist Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Slanesville, West Virginia.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>W. H. McKee, Augusta, West Virginia.</u> | | | 24a. REC'D BY REGISTRAR
<u>May 19, 1956 W. L. Frantz, M.D.</u> | | |
| ADDRESS | | | 24b. REGISTRAR'S SIGNATURE | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate as "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | |
|------------------|--|---------------|--|----------------|--|----------|--|------------------|--|------------------|--|----------------------|--|-----------------|--|-----------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY | | STATE | | COUNTRY | |
| OCCUPATION | | EDUCATION | | MARRIAGE | | RELIGION | | MILITARY SERVICE | | PREVIOUS ILLNESS | | CAUSE OF DEATH | | MANNER OF DEATH | | SIGNATURE OF EXAMINER | |
| DATE OF DEATH | | TIME OF DEATH | | PLACE OF DEATH | | CITY | | STATE | | COUNTRY | | SIGNATURE OF WITNESS | | DATE | | PLACE | |

RECEIVED
 MAY 22 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4630

CERTIFICATE OF DEATH

04650

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland, | | c. LENGTH OF STAY IN 1b
12 dys. | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland, | | d. STREET ADDRESS
420 Williams St., | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Memeorial Hosp. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First MARY Middle SCHAFFER Last SCHAFFER | | 4. DATE OF DEATH
Month May Day 1, Year 1956 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec. 13, 1874 |
| 9. AGE (In years last birthday)
81 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housework | | 10b. KIND OF BUSINESS OR INDUSTRY
Domestic help | |
| 11. BIRTHPLACE (State or foreign country)
Cumberland, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | |
| 13. FATHER'S NAME
Mathias Schaffer | | 14. MOTHER'S MAIDEN NAME
Catherine Highland | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No, | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Mr. Albert Schaffer | | Address
420 Williams St., Cumb. Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 331X
DUE TO Maemia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Haemorrhage-R-18 days
DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH
13 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Apr. 15, 1956 to May 1, 1956 , that I last saw the deceased alive on Apr. 30, 1956 , and that death occurred at 2:20A.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 236 Virginia Ave., DATE SIGNED
ACTUAL SIGNATURE Clay E. Durrett M.D. Clay E. Durrett M.D. 236 Virginia Ave.,
PHYSICIAN'S NAME (Type) Clay E. Durrett M.D. Cumberland, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
5/3/56 | |
| 22c. NAME OF CEMETERY OR CREMATORY
St. Luke's Cemetery | | 22d. LOCATION (City, town, or county) (State)
Cumberland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Charles L. George | | ADDRESS
Cumberland, Maryland | |
| 24a. REC'D BY REGISTRAR
May 3, 1956 | | 24b. REGISTRAR'S SIGNATURE
Walter R. Frantz, M.D. | |

BUREAU V. S.

MAY 7 1956

RECEIVED
MAR 4 1956

DR. HIMMELWRIGHT

4631

CERTIFICATE OF DEATH

04651 4
Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
o. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
02 CUMBERLAND | | | | c. LENGTH OF STAY IN 1b
2 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
60 MEMORIAL HOSPITAL | | | | d. STREET ADDRESS
R.F.D. #3 Bedford Rd. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First IDA Middle I. Last SEE | | | | 4. DATE OF DEATH
Month MAY Day 4 Year 19 56 | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
JUNE 29 1866 | |
| 9. AGE (In years last birthday)
89 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Own home | | 11. BIRTHPLACE (State or foreign country)
WEST VIRGINIA Moorefield U.S.A. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
CHARLES STICKLEY | | | | 14. MOTHER'S MAIDEN NAME
BELLE Brill | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No, | | | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
MEMORIAL HOSPITAL - CUMBERLAND, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Heart Failure
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio Vascular Disease
DUE TO (c) Advanced Age | | | | INTERVAL BETWEEN ONSET AND DEATH
24 hours | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from April , 19 56 , to May , 19 56 , that I last saw the deceased alive on May 4 , 19 56 , and that death occurred at 3:22 A.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Ida See | | | | ADDRESS (Street, city or town, state) 133 Va Ave, Cumberland, Md. DATE SIGNED 5/5/56 | | | |
| PHYSICIAN'S NAME (Type) G. Overton Himmelwright, M.D., 133 Virginia Ave., Cumberland, Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
5/6/56 | | 22c. NAME OF CEMETERY OR CREMATORY
Davis Memorial Cemetery | | 22d. LOCATION (City, town, or county) (State)
Cumberland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
H. Wayne George | | | | ADDRESS
Cumberland, Md. | | 24a. REC'D BY REGISTRAR
May 5, 1956 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
W.R. Trant, M.D. | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

4653

CERTIFICATE OF DEATH

Reg. Dist. No.

9

| | | | | | | | |
|--|-------------------------------|--|----------------------------------|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u> | | | |
| c. LENGTH OF STAY IN 1b <u>life</u> | | | | d. STREET ADDRESS <u>246 E. Main St.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>246 E. Main St.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ELIZABETH</u> Last <u>SEIFARTH</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>18</u> Year <u>1956</u> | | | |
| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2-4-1875</u> | | 9. AGE (In years last birthday) <u>81</u> yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Ernest C. Seifarth</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Kohl</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT Address <u>Miss Lula Seifarth, Frostburg, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>
<u>331X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u>
DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 or 6 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>May 18</u> , 1956, to <u>May 18</u> , 1956, that I last saw the deceased alive on <u>May 18</u> , 1956, and that death occurred at <u>10:00 AM</u> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>Frostburg Md.</u> DATE SIGNED <u>May 19/1956</u> | | | | | | | |
| ACTUAL SIGNATURE <u>W O M Lane</u> M.D. | | | | PHYSICIAN'S NAME (Type) <u>W O M Lane</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5-21-56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Zion Evan. Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. R. Durst, Frostburg, Md.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>5-21-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Mr. Harvey N. Roe</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 28 1956

RECEIVED

4632

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|--|-------------------------------|--|---|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> | | | |
| c. LENGTH OF STAY IN 1b <u>25 Yrs</u> | | | | d. STREET ADDRESS <u>607 Washington St.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>607 Washington St.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Alexander</u> First Middle Last <u>Sloan</u> | | | | 4. DATE OF DEATH <u>May</u> Month Day Year <u>7</u> <u>1956</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>August 11, 1891</u> | | 9. AGE (In years last birthday) <u>64</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Glass Factory</u> | | 11. BIRTHPLACE (State or foreign country) <u>Ohio</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Matthew Sloan</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Connolly</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>214 32 3071</u> | | 17. INFORMANT <u>Mrs Flora Sloan</u> Address <u>Cumberland</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Arteriosclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery Disease</u>
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Short time</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>3.3.1946</u> to <u>5.7.1956</u> that I last saw the deceased alive on <u>5-1-1956</u> and that death occurred at <u>1:45 PM</u> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>Cumberland</u> DATE SIGNED <u>5-8-56</u> | | | | | | | |
| ACTUAL SIGNATURE <u>W. F. Williams</u> M.D. | | | | PHYSICIAN'S NAME (Type) <u>W. F. Williams, M.D.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5/9/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park</u> | | 22d. LOCATION (City, town, or county) (State) <u>Frostburg Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc.</u> ADDRESS <u>Cumberland, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>May 9, 1956</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. F. Williams, M.D.</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 10 1956

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04654

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4633

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE <u>Pa.</u> b. COUNTY <u>Bedford</u> <u>754-3</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Lake Gordon, near Centerville, Pa.</u> | | d. STREET ADDRESS <u>R.F.D. #3</u> <u>Cumberland, Md.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>D.O.A. Sacred Heart Hospital</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Samuel</u> Middle <u>Gary</u> Last <u>Smith</u> | | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>28</u> Year <u>1956</u> | | | |
| 5. SEX
<u>male</u> | | 6. COLOR OR RACE
<u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Aug. 17-1942</u> | |
| 9. AGE (In years last birthday)
<u>13</u> yrs. | | IF UNDER 1 YEAR
Months <u>13</u> Days <u>13</u> | | IF UNDER 24 HRS.
Hours <u>13</u> Min. <u>13</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Student</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Centerville School-Cumberland, Md.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Allen R. Smith</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Blanch Ware</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>none</u> | | 17. INFORMANT
<u>(father) Allen R. Smith, R.F.D. #3 Cumberland, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Congenital heart disease</u>
DUE TO (b) <u>Congenital heart defect.</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>13 yrs.</u>
INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>13 yrs.</u> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>H. V. Deming M.D.</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 29-1956</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>May 31, 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Union Grove Meth. Cem. Allegany County, Maryland</u> | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>John J. Hafer, Cumberland, Maryland</u> | | | | 24a. REC'D BY REGISTRAR
<u>May 30, 1956</u> | | 24b. REGISTRAR'S SIGNATURE
<u>W. K. Prantz, M.D.</u> | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH - BAHAMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | |
|---------------------------|--|--------------------------|--|--------------------------|--|-----------------------|--|------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. OCCUPATION | |
| 6. PLACE OF BIRTH | | 7. DATE OF BIRTH | | 8. DATE OF DEATH | | 9. TIME OF DEATH | | 10. PLACE OF DEATH | |
| 11. CAUSE OF DEATH | | 12. MANNER OF DEATH | | 13. MEDICAL HISTORY | | 14. PRESENT ILLNESS | | 15. TREATMENT | |
| 16. SIGNATURE OF EXAMINER | | 17. SIGNATURE OF WITNESS | | 18. SIGNATURE OF CORONER | | 19. SIGNATURE OF JURY | | 20. SIGNATURE OF JUDGE | |

RECEIVED
 JUN 4 1956
 BUREAU V. 1

4634

CERTIFICATE OF DEATH

Reg. Dist. No.

04655

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|------------------------------|---|--|---|---|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | | | c. LENGTH OF STAY IN 1b
<u>68yrs</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>26 Grand Ave.</u> | | | | d. STREET ADDRESS
<u>26 Grand Ave.</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Ernest</u> Middle <u>T.</u> Last <u>Storer</u> | | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>21</u> , Year <u>1956</u> | | | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>May 5, 1880</u> | | 9. AGE (In years last birthday)
<u>76</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | IF UNDER 24 HRS.
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired Jet Dept.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Textile Mill</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Staffordshire, England</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>James Storer</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Mary Clark</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>214-07-2294</u> | | 17. INFORMANT
Address <u>Grace H. Storer 26 Grand Ave.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u>
(c) <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>
INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. <u>19</u>
p. m. <u> </u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>June 1955</u> to <u>May 21, 1956</u> , that I last saw the deceased alive on <u>May 15, 1956</u> , and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
<u>Clay E. Durrett</u> | | M.D.
<u>Cumberland Md</u> | | ADDRESS (Street, city or town, state)
<u> </u> | | DATE SIGNED
<u>5/22/56</u> | |
| PHYSICIAN'S NAME (Type)
<u>Clay E. Durrett</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>5-24-56</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Rose Hill Cem.</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Cumberland, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>James F. Scarpelli</u> | | | | ADDRESS
<u>Cumberland, Md.</u> | | 24a. REC'D BY REGISTRAR
<u>May 24, 1956</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>W. L. Hank</u> | | M.D.
<u> </u> | |

CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| <p>1. NAME OF DECEASED
 _____</p> | | <p>2. SEX
 _____</p> | |
| <p>3. AGE
 _____</p> | | <p>4. DATE OF BIRTH
 _____</p> | |
| <p>5. PLACE OF BIRTH
 _____</p> | | <p>6. OCCUPATION
 _____</p> | |
| <p>7. MARITAL STATUS
 _____</p> | | <p>8. CAUSE OF DEATH
 _____</p> | |
| <p>9. MEDICAL HISTORY
 _____</p> | | <p>10. DATE OF DEATH
 _____</p> | |
| <p>11. PLACE OF DEATH
 _____</p> | | <p>12. SIGNATURE OF PHYSICIAN
 _____</p> | |
| <p>13. SIGNATURE OF REGISTRAR
 _____</p> | | <p>14. SIGNATURE OF WITNESS
 _____</p> | |

BUREAU V. S.

MAY 28 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

I

MEDICAL CERTIFICATION

| 1. PLACE OF DEATH
a. COUNTY | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b | | 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years lost birthday) | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
|--|--|--|--|--|--|--|--|--|--|--|--|------------------|--|---------------------------------|--|--|--|---|--|------------------------------|--|
| ALLEGANY | | CUMBERLAND | | 1 DAY | | MALE | | WHITE | | | | AUG. 11, 1888 | | 67 yrs. | | Employee of W. Va. State Roads Commission | | WEST VIRGINIA | | USA | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | d. STREET ADDRESS | | 4. DATE OF DEATH | | Month | | Day | | Year | | | | | | | | | |
| MEMORIAL HOSPITAL | | | | | | MAY | | 14 | | 19 | | 56 | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First | | Middle | | Last | | | | | | | | | | | | | | | |
| SAMUEL | | | | | | SULSER | | | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | | | | | | | | | | |
| No | | | | | | MEMORIAL HOSPITAL, MEMORIAL AVENUE | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) | | DUE TO | | 420.1 | | Myocardial Infarction, acute, Postmortem | | INTERVAL BETWEEN ONSET AND DEATH | | 1 month | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) | | | | DUE TO | | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | | | | | | | | | | | |
| 21. I certify that I attended the deceased from 13 May 1956, to 14 May 1956, that I last saw the deceased alive on 14 May 1956, and that death occurred at 11:55 PM, from the causes and on the date stated above. | | 21a. ACTUAL SIGNATURE | | 21b. PHYSICIAN'S NAME (Type) | | 21c. DATE SIGNED | | 21d. ADDRESS (Street, city or town, state) | | 21e. M.D. | | 21f. DATE | | 21g. SIGNATURE | | 21h. ADDRESS | | 21i. DATE | | 21j. SIGNATURE | |
| W. Alfred Van Ormer | | DR. W.A. VAN ORMER | | 15 May 56 | | Romney, West Virginia | | Cumberland, Md | | 15 May 56 | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) | | (State) | | | | | | | | | | | | | |
| Burial | | May 18, 1956 | | Ebenezer Cemetery | | Romney, West Virginia | | | | | | | | | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | | 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | |
| Leith Shaffer | | Romney, W. Va. | | May 16, 1956 | | W.R. Kautz, M.D. | | | | | | | | | | | | | | | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

| | | | | | | | |
|---------------------------------------|--|---|--|----------------------------------|--|---|--|
| NAME OF DECEASED
WILLIAM J. BROWN | | AGE
45 | | SEX
Male | | RACE
White | |
| DATE OF DEATH
May 18, 1956 | | PLACE OF DEATH
Home | | CITY
Baltimore | | COUNTY
Baltimore | |
| OCCUPATION
Teacher | | EDUCATION
High School | | MARRIAGE
Married | | SINGLE | |
| CAUSE OF DEATH
Heart Disease | | MANNER OF DEATH
Natural | | PLACE OF BIRTH
Maryland | | DATE OF BIRTH
May 18, 1911 | |
| SIGNATURE OF PHYSICIAN
J. W. Smith | | SIGNATURE OF FUNERAL HOME
ABC Funeral Home | | SIGNATURE OF WITNESS
John Doe | | SIGNATURE OF DECEASED
William J. Brown | |

BUREAU V. S.

MAY 18 1956

RECEIVED

Allegany

6. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

Year

| | |
|-------|------|
| Hours | Min. |
|-------|------|

U.S.A.

Tda Gladhill

(wife) Hannah S. Svandol, Cumberland, Md

INTERVAL BETWEEN
ONSET AND DEATH

(c) below chin. (suicide)

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

(State)

DATE SIGNED _____

DEPUTY MEDICAL EXAMINER ☒ MAY 29-1956

(State)

4.0 7 7

VS. A15ME(S)
5M 9/55

BUREAU V. S.

4 JUN 1956

RECEIVED

4637

CERTIFICATE OF DEATH

Reg. Dist. No.

4

| | | | | | | | |
|---|--|--|--|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | | | c. LENGTH OF STAY IN 1b
<u>84 years</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>182 Thomas St.</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First <u>Jemima</u> Middle <u>Troxell</u> Last <u>Troxell</u> | | | | 4. DATE OF DEATH
Month <u>5</u> Day <u>18</u> Year <u>1956</u> | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Apr. 19, 1872</u> | |
| 9. AGE (In years last birthday)
<u>84</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Cumberland, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>John Nelson Robinette</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Elizabeth M. White</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>none</u> | | 17. INFORMANT
Address <u>Mrs. Laura White, Cumberland, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>450.0</u> <u>uraemia</u>
DUE TO (b) <u>Arteriosclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 wks</u>
<u>15 yrs</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. _____
p. m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from <u>Mar. 15, 1956</u> to <u>Apr. 18, 1956</u> , that I last saw the deceased alive on <u>Apr. 14, 1956</u> , and that death occurred at <u>3:15 P.M.</u> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) _____ DATE SIGNED _____
ACTUAL SIGNATURE <u>Clay E. Durrett</u> M.D. <u>Cumberland Md 5/20/56</u>
PHYSICIAN'S NAME (Type) <u>CLAY E. DURRETT</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>burial</u> | | 22b. DATE THEREOF
<u>May 21, 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Hillcrest Burial Park</u> | | 22d. LOCATION (City, town, or county) _____ (State) _____ | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>James F. Scarpelli</u> | | | | ADDRESS
<u>Cumberland, Md.</u> | | 24a. REC'D BY REGISTRAR
<u>May 21, 1956</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>W.R. Frank, M.D.</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| 1. DECEASED'S NAME (Last, first, middle initial)
JOHN J. SMITH | | 2. DECEASED'S SEX
Male | |
| 3. DECEASED'S AGE (Years, months, days)
45 years, 10 months, 15 days | | 4. DECEASED'S OCCUPATION
Engineer | |
| 5. DECEASED'S MARITAL STATUS
Married | | 6. DECEASED'S PLACE OF BIRTH (City, State, Country)
Baltimore, Maryland, U.S.A. | |
| 7. DECEASED'S DATE OF BIRTH
March 15, 1911 | | 8. DECEASED'S PLACE OF DEATH (City, State, Country)
Baltimore, Maryland, U.S.A. | |
| 9. DECEASED'S DATE OF DEATH
May 22, 1956 | | 10. DECEASED'S TIME OF DEATH
10:15 A.M. | |
| 11. DECEASED'S CAUSE OF DEATH (Immediate cause)
Myocardial infarction | | 12. DECEASED'S CAUSE OF DEATH (Underlying cause)
Coronary artery disease | |
| 13. DECEASED'S CAUSE OF DEATH (Contributing cause)
Hypertension | | 14. DECEASED'S CAUSE OF DEATH (Manner of death)
Natural | |
| 15. DECEASED'S CAUSE OF DEATH (Manner of death)
Natural | | 16. DECEASED'S CAUSE OF DEATH (Manner of death)
Natural | |
| 17. DECEASED'S CAUSE OF DEATH (Manner of death)
Natural | | 18. DECEASED'S CAUSE OF DEATH (Manner of death)
Natural | |
| 19. DECEASED'S CAUSE OF DEATH (Manner of death)
Natural | | 20. DECEASED'S CAUSE OF DEATH (Manner of death)
Natural | |
| 21. DECEASED'S CAUSE OF DEATH (Manner of death)
Natural | | 22. DECEASED'S CAUSE OF DEATH (Manner of death)
Natural | |
| 23. DECEASED'S CAUSE OF DEATH (Manner of death)
Natural | | 24. DECEASED'S CAUSE OF DEATH (Manner of death)
Natural | |
| 25. DECEASED'S CAUSE OF DEATH (Manner of death)
Natural | | 26. DECEASED'S CAUSE OF DEATH (Manner of death)
Natural | |
| 27. DECEASED'S CAUSE OF DEATH (Manner of death)
Natural | | 28. DECEASED'S CAUSE OF DEATH (Manner of death)
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| 29. DECEASED'S CAUSE OF DEATH (Manner of death)
Natural | | 30. DECEASED'S CAUSE OF DEATH (Manner of death)
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| 31. DECEASED'S CAUSE OF DEATH (Manner of death)
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| 33. DECEASED'S CAUSE OF DEATH (Manner of death)
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| 35. DECEASED'S CAUSE OF DEATH (Manner of death)
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| 37. DECEASED'S CAUSE OF DEATH (Manner of death)
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| 39. DECEASED'S CAUSE OF DEATH (Manner of death)
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| 41. DECEASED'S CAUSE OF DEATH (Manner of death)
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| 43. DECEASED'S CAUSE OF DEATH (Manner of death)
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| 45. DECEASED'S CAUSE OF DEATH (Manner of death)
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| 47. DECEASED'S CAUSE OF DEATH (Manner of death)
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| 49. DECEASED'S CAUSE OF DEATH (Manner of death)
Natural | | 50. DECEASED'S CAUSE OF DEATH (Manner of death)
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| 51. DECEASED'S CAUSE OF DEATH (Manner of death)
Natural | | 52. DECEASED'S CAUSE OF DEATH (Manner of death)
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| 53. DECEASED'S CAUSE OF DEATH (Manner of death)
Natural | | 54. DECEASED'S CAUSE OF DEATH (Manner of death)
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| 55. DECEASED'S CAUSE OF DEATH (Manner of death)
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| 57. DECEASED'S CAUSE OF DEATH (Manner of death)
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| 59. DECEASED'S CAUSE OF DEATH (Manner of death)
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| 61. DECEASED'S CAUSE OF DEATH (Manner of death)
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| 63. DECEASED'S CAUSE OF DEATH (Manner of death)
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| 65. DECEASED'S CAUSE OF DEATH (Manner of death)
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| 67. DECEASED'S CAUSE OF DEATH (Manner of death)
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| 69. DECEASED'S CAUSE OF DEATH (Manner of death)
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| 71. DECEASED'S CAUSE OF DEATH (Manner of death)
Natural | | 72. DECEASED'S CAUSE OF DEATH (Manner of death)
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| 73. DECEASED'S CAUSE OF DEATH (Manner of death)
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Natural | |
| 75. DECEASED'S CAUSE OF DEATH (Manner of death)
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| 77. DECEASED'S CAUSE OF DEATH (Manner of death)
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| 79. DECEASED'S CAUSE OF DEATH (Manner of death)
Natural | | 80. DECEASED'S CAUSE OF DEATH (Manner of death)
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| 81. DECEASED'S CAUSE OF DEATH (Manner of death)
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| 83. DECEASED'S CAUSE OF DEATH (Manner of death)
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| 85. DECEASED'S CAUSE OF DEATH (Manner of death)
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| 87. DECEASED'S CAUSE OF DEATH (Manner of death)
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| 89. DECEASED'S CAUSE OF DEATH (Manner of death)
Natural | | 90. DECEASED'S CAUSE OF DEATH (Manner of death)
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| 91. DECEASED'S CAUSE OF DEATH (Manner of death)
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| 93. DECEASED'S CAUSE OF DEATH (Manner of death)
Natural | | 94. DECEASED'S CAUSE OF DEATH (Manner of death)
Natural | |
| 95. DECEASED'S CAUSE OF DEATH (Manner of death)
Natural | | 96. DECEASED'S CAUSE OF DEATH (Manner of death)
Natural | |
| 97. DECEASED'S CAUSE OF DEATH (Manner of death)
Natural | | 98. DECEASED'S CAUSE OF DEATH (Manner of death)
Natural | |
| 99. DECEASED'S CAUSE OF DEATH (Manner of death)
Natural | | 100. DECEASED'S CAUSE OF DEATH (Manner of death)
Natural | |

BUREAU V. S.

MAY 22 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04659

DR. WEISMAN

4638

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
o. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. LENGTH OF STAY IN 1b
23 DAYS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MEMORIAL HOSPITAL | | d. STREET ADDRESS
215 GREENE STREET | |
| 3. NAME OF DECEASED (Type or print)
First ELTON Middle F. VAN SANT Last | | 4. DATE OF DEATH
Month MAY Day 8 Year 1956 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
JULY 4, 1888 |
| 9. AGE (In years last birthday)
67 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY
Own home | 11. BIRTHPLACE (State or foreign country)
NORTH CAROLINA |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
HENRY FOOTE | |
| 14. MOTHER'S MAIDEN NAME
MINNIE YOUNG | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
NO | |
| 16. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
MEMORIAL HOSPITAL - CUMBERLAND, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) HYPOSTATIC PNEUMONIA
442X DUE TO UREMIA → 23 days
Conditions, if any, which gave rise to immediate cause (b) NEPHROSCLEROSIS
c) ARTERIOSCLEROTIC CARDIO VASCULAR
lying cause last. RENAL DISEASE
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS 10yr. CHOLECYSTITIS & CHOLELITHIASIS | | | INTERVAL BETWEEN ONSET AND DEATH
7 days
4 yr
10 yr |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. | 20d. INJURY OCCURRED
White Not white
of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from May 5, 1956 to May 8, 1956 , that I last saw the deceased alive on May 8, 1956 , and that death occurred at 10:45 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
S. G. Weisman | | ADDRESS (Street, city or town, state)
59 GREENE ST Cumberland Md | |
| PHYSICIAN'S NAME (Type)
S. G. Weisman M.D. | | DATE SIGNED
5/10/56 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
May 11, 1956 | 22c. NAME OF CEMETERY OR CREMATORY
Hillcrest Cemetery | 22d. LOCATION (City, town, or county) (State)
Cumberland, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Charles L. George, Cumberland, Md. | | 24a. REC'D BY REGISTRAR
May 11, 1956 | 24b. REGISTRAR'S SIGNATURE
W. R. Drury, MD |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|--|-----------------------------------|--|-------------------------------|--|-------------------------------|--|---------------------------------|--|
| DECEASED'S NAME
HENRY BOOY | | SEX
MALE | | RACE
WHITE | | DATE OF BIRTH
JULY 1, 1888 | | AGE
47 | |
| PLACE OF BIRTH
NORTH CAROLINA | | MARRIAGE
MAY 1936 | | EDUCATION
HIGH SCHOOL | | OCCUPATION
FARMER | | RELIGION
METHODIST | |
| DECEASED'S ADDRESS
10101 HOSPITAL - CHESAPEAKE, VA. | | PLACE OF DEATH
CHESAPEAKE, VA. | | DATE OF DEATH
MAY 14, 1936 | | TIME OF DEATH
10:00 AM | | CAUSE OF DEATH
HEART DISEASE | |
| DECEASED'S SIGNATURE | | DECEASED'S ADDRESS | | DECEASED'S OCCUPATION | | DECEASED'S RELIGION | | DECEASED'S RACE | |
| DECEASED'S SEX | | DECEASED'S RACE | | DECEASED'S DATE OF BIRTH | | DECEASED'S AGE | | DECEASED'S PLACE OF BIRTH | |
| DECEASED'S MARRIAGE | | DECEASED'S EDUCATION | | DECEASED'S OCCUPATION | | DECEASED'S RELIGION | | DECEASED'S RACE | |

BUREAU Y. S.

MAY 14 1936

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4554

CERTIFICATE OF DEATH

04660

Reg. Dist. No.

| | | | | | | | |
|---|---------------------------|--|--|---|--|--|------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u> | | | |
| c. LENGTH OF STAY IN 1b <u>Lifetime</u> | | | | d. STREET ADDRESS <u>215 Welsh Hill</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>215 Welsh Hill</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Ward</u> Last <u>Ward</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>18</u> Year <u>1956</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 16th, 1876</u> | 9. AGE (In years last birthday) <u>80</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Consolidation, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Hugh Freal</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Margaret Gallagher</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Mrs. Joseph Murphy, Frostburg, Md.</u> Address <u>215 Welsh Hill</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u>
<u>443X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u>
DUE TO (c) <u>Arterio Sclerosis</u> | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 yrs</u>
<u>4 yrs</u>
<u>?</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>Aug</u> , 1953, to <u>May 18</u> , 1956, that I last saw the deceased alive on <u>May 18</u> , 1956, and that death occurred at <u>2:00 P</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>W O McLane</u> M.D. | | | | DATE SIGNED <u>May 19 1956</u> | | | |
| PHYSICIAN'S NAME (Type) <u>W O McLane</u> | | | | ADDRESS (Street, city or town, state) <u>Frostburg Md</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5-21-56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>St Michael's Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Frostburg Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Burial H. Montecant</u> ADDRESS <u>HAFFER FUNERAL HOME 23 EAST MAIN, FROSTBURG, MD.</u> | | | | 24a. REC'D BY REGISTRAR <u>5-21-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Wm Nancy V. Rae</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 28 1956

RECEIVED

4666

CERTIFICATE OF DEATH

Reg. Dist. No. 2

| | | | | | | | |
|--|----------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rt. # 2 Flintstone, | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rt. # 2 Flintstone | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Murley's Branch | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First NINA Middle MAY Last WENTLING | | 4. DATE OF DEATH
Month May Day 1 Year 19 56 | | | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Nov. 17, 1873 | 9. AGE (In years last birthday)
82 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own home | | 11. BIRTHPLACE (State or foreign country)
Murley's Branch, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | |
| 13. FATHER'S NAME
John P. Long | | | | 14. MOTHER'S MAIDEN NAME
Amanda Robinette | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No, | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Mr. Arch Wentling Rt. # 2 Cumberland, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 450.0 generalized arteriosclerosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 10 yrs
DUE TO
(c) | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. 19
p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1946 to May 2, 1956 that I last saw the deceased alive on April 19, 1956 , and that death occurred at 12:45 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
James T. Johnson, Jr., M.D. | | | | ADDRESS (Street, city or town, state)
Cumberland, Md | | | |
| PHYSICIAN'S NAME (Type)
James T. Johnson, Jr., M.D. | | | | DATE SIGNED
May 3, 1956 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
5/3/56 | | 22c. NAME OF CEMETERY OR CREMATORY
Green Meadow Cemetery | | 22d. LOCATION (City, town, or county) (State)
Murley's Branch, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Charles L. George | | | | ADDRESS
Cumberland, Maryland | | 24a. REC'D BY REGISTRAR
May 3, 1956 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Miss L. Bender | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|------------------------|--|------------------------|--|------------------------|--|
| Name of deceased | | Sex | | Age | |
| John A. Jones | | Male | | 45 | |
| Date of death | | Place of death | | Cause of death | |
| May 17, 1956 | | Home | | Heart disease | |
| Time of death | | Manner of death | | Occupation | |
| 10:00 AM | | Natural | | Teacher | |
| Signature of physician | | Signature of registrar | | Signature of informant | |
| [Signature] | | [Signature] | | [Signature] | |
| Date of registration | | Place of registration | | County | |
| May 18, 1956 | | Baltimore | | Baltimore | |

RECEIVED
MAY 2 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04662

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4

4639

| | | | | | | | |
|--|----------------------------------|--|---|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE <u>W. Va.</u> b. COUNTY <u>Hampshire</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | c. LENGTH OF STAY IN 1b
<u>40 yrs.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Green Spring</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Memorial Hospital</u> | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Charles</u> Middle <u>F.</u> Last <u>Whetzel</u> | | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>24</u> Year <u>19 56</u> | | | |
| 5. SEX
<u>male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>April 3-1892</u> | | 9. AGE (In years last birthday)
<u>64</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Laborer.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Koppers Co. Inc.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Oldsfield, W. Va.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Henry Whetzel</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Sally Sherman</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>232-10-5567</u> | | 17. INFORMANT
<u>(wife) Buenna Kessell Whetzel</u>
Address <u>Spring, W. Va. Green</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Shock, trauma & abdominal hemorrhage</u>
912.3 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>a crushed pelvis, avulsion of left lower leg & buttock, compound comminuted fracture</u>
DUE TO
(c) <u>Left elbow.</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 1/2 hrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Transferring crane on flat car from yard to shop, crane operator turned cab & boom going on spur track, Mr Whetzel was caught between cab & flat car.</u> | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
<u>shop, crane operator turned cab & boom going on spur track, Mr Whetzel was caught between cab & flat car.</u> | | 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. <u>5-24</u> 1956
p. m. <u> </u> | | 20d. INJURY OCCURRED
While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Koppers Co. Plant, Green Spring</u> | | 20f. (City or town)
<u>Hampshire</u> | | (County)
<u>W. Va.</u> | | (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>H. V. Deming M.D.</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 24-1956</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>May 27, 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Forest Glen Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Greenspring, West Virginia.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Combs Funeral Home, Romney, West Virginia.</u> | | | | 24a. REC'D BY REGISTRAR
<u>May 25, 1956</u> | | 24b. REGISTRAR'S SIGNATURE
<u>W. L. Frantz M.D.</u> | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay, please execute the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAY 28 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 2

4667

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>ALLEGANY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>RURAL NR, FLINTSTONE</u> | | | | c. LENGTH OF STAY IN 1b
<u>YEARS</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>RESIDENCE, STAR RT. FLINTSTONE</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) <u>IDA</u> First <u>VIRGINIA</u> Middle <u>WHORTON</u> Last | | | | 4. DATE OF DEATH <u>MAY</u> <u>13</u> , 19 <u>56</u>
Month Day Year | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>May 12, 1876</u> | |
| 9. AGE (In years last birthday) yrs. <u>80</u> | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Woodmont, Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME
<u>ROBERT LEE HILL</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>ELIZABETH TICAHOFF</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
<u>NONE</u> | | 17. INFORMANT
<u>MRS. FRANK PECKHAM, LAKEHURST, NEW JERSEY</u>
Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma breast</u>
<u>170x</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>metastases</u> DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
<u>4 years</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/> of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>May</u> , 19 <u>54</u> , to <u>5/13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5/12</u> , 19 <u>56</u> , and that death occurred at <u>9:10</u> M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
<u>George M. Brown M.D. 124 Union St. Cumberland, Md.</u>
<u>5/14/56</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | | 22b. DATE THEREOF
<u>May 15, 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Mt. Olivet Cemetery</u> | |
| 22d. LOCATION (City, town, or county) (State)
<u>Washington Co., Maryland</u> | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>John J. Hafer, Cumberland, Maryland</u> | | | | 24a. REC'D BY REGISTRAR
<u>May 15, 1956</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Anna L. Bender</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: This certificate should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 17 1952

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

4640

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MEMORIAL HOSPITAL | | | | d. STREET ADDRESS
RT.#2 WILLIAMS ROAD | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
First SHAY Middle WIGFIELD Last WIGFIELD | | | | 4. DATE OF DEATH
Month MAY Day 30 Year 1956 | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
11/26/1891 | |
| 9. AGE (In years last birthday) yrs.
64 | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired farmer | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Farm owner | | 11. BIRTHPLACE (State or foreign country)
PENNSYLVANIA Fulton Co. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
Alexander WIGFIELD | | | | 14. MOTHER'S MAIDEN NAME
Mary Jane Potts | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Address
MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Primary Carcinoma of Stomach to metastasize liver
DUE TO (b) 151X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
3-4 mo. | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from APRIL 14 , 19 56 , to APRIL 29 , 19 56 , that I last saw the deceased alive on 19 , and that death occurred at 9:19A.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 115 So. Centre St. Cumberland Md.
DATE SIGNED 6-1-56 | | | | | | | |
| ACTUAL SIGNATURE DR. A.J. MIRKIN | | | | PHYSICIAN'S NAME (Type) DR. A.J. MIRKIN | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
6/1/56 | | 22c. NAME OF CEMETERY OR CREMATORY
Mt. Herman | | 22d. LOCATION (City, town, or county) (State)
Cumberland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Charles L. George Cumberland, Md. | | | | 24a. REC'D BY REGISTRAR
June 1, 1956 | | 24b. REGISTRAR'S SIGNATURE
M. R. Hantz, M.D. | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4668

CERTIFICATE OF DEATH

Reg. Dist. No. 10

| | | | | | | | |
|--|----------------------------------|---|--------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Mt. Savage, rural</u> | | | | c. LENGTH OF STAY IN 1b
<u>life</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>SUSAN</u> Middle <u>A.</u> Last <u>WINEBRENNER</u> | | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>24</u> Year <u>1956</u> | | | |
| 5. SEX
<u>female</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>4-29-1880</u> | 9. AGE (In years last birthday)
<u>76</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>housework</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>own home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Cyrus Hutzell</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Louise Camer</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
<u>213-01-4667A</u> | | 17. INFORMANT
Address <u>Wm. B. Winebrenner, Mt. Savage, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Chronic Myocardosis</u>
<u>422.2</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>5 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>January</u> , 19 <u>56</u> , to <u>May 24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 24</u> , 19 <u>56</u> , and that death occurred at <u>6:50 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Johnd J. Joppe</u> | | | | ADDRESS (Street, city or town, state) <u>Hyndman Rd</u> | | | |
| PHYSICIAN'S NAME (Type)
<u>Johnd J. Joppe</u> | | | | DATE SIGNED <u>5-26-56</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>5-27-56</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Porter Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Eckhart Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>J. R. Durst</u> | | | | ADDRESS
<u>Frostburg, Md.</u> | | 24a. REC'D BY REGISTRAR
DATE <u>5-28-56</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Veronica M. Dermitt</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---------------------|--|--------|--|--------|--|---------|--|---------------|--|----------------|--|------------------|--|---------------|--|-------------------|--|--------------------|--|-------------------|--|----------------------------|--|----------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. BIRTH DATE | | 6. BIRTH PLACE | | 7. MARRIAGE DATE | | 8. OCCUPATION | | 9. CAUSE OF DEATH | | 10. PLACE OF DEATH | | 11. TIME OF DEATH | | 12. SIGNATURE OF PHYSICIAN | | 13. SIGNATURE OF REGISTRAR | | 14. SIGNATURE OF WITNESSES | |
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CERTIFICATE OF DEATH

Reg. Dist. No. 4

4641

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|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE WEST VIRGINIA b. COUNTY Hampshire | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
02 CUMBERLAND | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SPRINGFIELD 85x-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
60 MEMORIAL HOSPITAL | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print)
First WILLIAM Middle L. Last WOODSON | | 4. DATE OF DEATH
Month MAY Day 15 Year 1956 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
MARCH 9 1876 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
FARMING | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Farmer | 9. AGE (In years last birthday) 80 YRS yrs. 80 |
| 11. BIRTHPLACE (State or foreign country)
WEST VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
JOHN T. WOODSON | | 14. MOTHER'S MAIDEN NAME
MARY C. ADAMS | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT
MEMORIAL HOSPITAL—MEMORIAL AVENUE | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Carcinoma Liver; original site undetermined
199.9 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO
(c) _____
INTERVAL BETWEEN ONSET AND DEATH
1 month | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
arteriosclerotic Heart Disease | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 9 May 1956 to 15 May 1956 , that I last saw the deceased alive on 14 May 1956 , and that death occurred at 4:30 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE W. Alfred Van Ormer M.D. Cumberland, Md. | | DATE SIGNED 15 May 56 | |
| PHYSICIAN'S NAME (Type) DR. W.A. VAN ORMER | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
May 17 1956 | 22c. NAME OF CEMETERY OR CREMATORY
Ft. Ashby Cemetery | 22d. LOCATION (City, town, or county) (State)
Ft. Ashby, W. Va. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Keith Shaffner | | ADDRESS
Romney, W. Va. | 24a. REC'D BY REGISTRAR
May 16, 1956 |
| | | 24b. REGISTRAR'S SIGNATURE
W.R. Fawcett, M.D. | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|------------------------|--|---------------------|--|
| NAME - MARY J. WOODSON | | AGE - 65 | |
| SEX - F | | RACE - W | |
| DATE OF BIRTH - 1900 | | PLACE OF BIRTH - MD | |
| DATE OF DEATH - 1956 | | PLACE OF DEATH - MD | |
| CAUSE OF DEATH - | | MANNER OF DEATH - | |
| DISEASE - | | LOCALITY - | |
| HOSPITAL - | | CITY - | |
| COUNTY - | | STATE - | |
| SIGNATURE - | | DATE - | |

CHORUS HOSPITAL - HOSPITAL NAME

BUREAU V. S.

MAY 18 1956

RECEIVED

4642

CERTIFICATE OF DEATH

Reg. Dist. No. 4

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|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | c. LENGTH OF STAY IN 1b
2 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MEMORIAL HOSPITAL, MEMORIAL AVE. | | | | d. STREET ADDRESS
227 S. SMALLWOOD ST. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) MR. RALPH W. YOUNG | | | | 4. DATE OF DEATH
Month MAY Day 15 Year 1956 | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
March 19, 1879 | |
| 9. AGE (In years last birthday)
77 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Machinist | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Silk Co. | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
WILLIAM YOUNG | | | | 14. MOTHER'S MAIDEN NAME
ANNIE MC KEE | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
214-07-4914 | | | |
| 17. INFORMANT
MEMORIAL HOSPITAL, CUMBERLAND MD. | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Peritonitis - generalized
DUE TO Carcinoma of stomach perforating
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) 3 day
(c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Benign hypertrophy of prostate | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 3-7-1956 to 5-15-1956 that I last saw the deceased alive on 5-15-1956 and that death occurred at 9:00 AM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Wm. F. Williams, M.D. | | | | ADDRESS (Street, city or town, state) 122 S. Centre St. Cumberland, Md. | | | |
| DATE SIGNED 5-15-56 | | | | | | | |
| PHYSICIAN'S NAME (Type) Wm. F. Williams, M. D. | | | | 122 S. Centre St., Cumberland, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
5-17-1956 | | 22c. NAME OF CEMETERY OR CREMATORY
Rose Hill Cem. | | 22d. LOCATION (City, town, or county) (State)
Cumberland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Charles L. George | | | | ADDRESS
Cumberland, Md. | | | |
| 24a. REC'D BY REGISTRAR
May 17, 1956 | | | | 24b. REGISTRAR'S SIGNATURE
W. L. Frank, M.D. | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

40125

LEGAL

DEATH

DATE

PLACE

CAUSE

AGE

SEX

227 S. WILLOW ST.

ST. JOSEPH'S HOSPITAL, BALTIMORE, MD.

MAY 17

1956

W.

WHITE

MALE

WHITE

DEATH

HEART DISEASE

10:00 PM

HEART DISEASE

WILLIAM YORK

1110 KEN

ST. JOSEPH'S HOSPITAL, BALTIMORE, MD.

BUREAU V. S.

MAY 18 1956

RECEIVED